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**INVOLVING RISK CREATORS?
A LEGAL ANALYSIS OF PUBLIC-PRIVATE
PARTNERSHIPS AS A RESPONSE
TO TACKLE NON-COMMUNICABLE DISEASES**

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ABSTRACT

The prevention of non-communicable diseases (NCDs) remains a major public health challenge. The predominance of “soft” law approaches with the emphasis on cross-sector collaboration at the international level, the narrative that the private sector must be engaged in dealing with complex health challenges, the “new governance” theory, neoliberalism beliefs and resistance to perceived paternalistic interventions at the domestic level, has enabled public-private partnerships (PPPs) for NCD prevention to emerge as an alternative regulatory approach to stricter regulation in this context. This research examines PPPs for NCD prevention through a legal lens. Drawing from the broader taxonomy of PPP frameworks, it develops a definition of PPPs for NCD prevention by situating them within the context of PPPs in general and global health PPPs models. It then explores selected examples of PPPs involving the food and sweetened beverage industries, focused on product reformulation, to understand their potential and limitations as an alternative tool to stricter regulatory measures to promote public health. The most pressing concern remains the inherent conflict of interest: the food industry has a commercial interest in promoting and maximizing the sales of unhealthy products that are driving the burden of NCDs. Despite the shortcomings and the use of PPPs as a regulation avoidance mechanism, these “alternative regulatory tools” are still being adopted and encouraged. This thesis concludes by presenting two possible pathways. First, a practical legal approach that incorporates safeguards from established PPP frameworks, including the adoption of formal contractual arrangements (with accountability mechanisms, government-determined measurable targets, and enforceable consequences), to better align such partnerships with public health objectives. Second, from a theoretical perspective, it explores the concept of “social denormalization” as a legal and social tool to shift norms around unhealthy food production and consumption. Drawing on Article 5.3 of the WHO FCTC, it suggests denormalizing PPPs with the food industry, relying on the adoption of command-and-control regulations at the domestic level. This will drive meaningful shifts at the industry level, shaping societal consumption patterns and genuinely promoting public health and NCD prevention.

Keywords: non-communicable diseases; public-private partnerships; public health law; regulatory approaches; unhealthy diets; food industry; conflict of interest; public health promotion; product reformulation; right to health.

RÉSUMÉ

La prévention des maladies non transmissibles (MNT) demeure un défi majeur de santé publique. La prédominance des approches relevant du « droit souple » au niveau international, mettant l'accent sur la collaboration intersectorielle, le discours selon lequel le secteur privé doit être mobilisé pour faire face à des enjeux sanitaires complexes, les théories de la « nouvelle gouvernance », les croyances néolibérales ainsi que la résistance aux interventions perçues comme paternalistes au niveau national ont favorisé l'émergence des partenariats public-privé (PPP) pour la prévention des MNT comme approche réglementaire alternative à une réglementation plus stricte dans ce domaine. Cette recherche analyse les PPP pour la prévention des MNT sous l'angle juridique. S'appuyant sur la taxonomie générale des cadres de PPP, elle élabore une définition des PPP pour la prévention des MNT en les situant dans le contexte plus large des PPP en général et des modèles de PPP en santé mondiale. Elle examine ensuite certains exemples de PPP impliquant les industries agroalimentaire et des boissons sucrées, centrés sur la reformulation des produits, afin de comprendre leur potentiel et leurs limites en tant qu'outil alternatif aux mesures réglementaires plus contraignantes pour la promotion de la santé publique. La préoccupation majeure demeure le conflit d'intérêts inhérent à ces partenariats: l'industrie alimentaire a un intérêt commercial à promouvoir et à maximiser la vente de produits malsains qui sont précisément à l'origine du fardeau des MNT. Malgré ces limites et l'utilisation des PPP comme mécanisme d'évitement réglementaire, ces « outils réglementaires alternatifs » continuent d'être adoptés et encouragés. Cette thèse conclut en présentant deux voies possibles. Premièrement, une approche juridique pragmatique intégrant des garanties issues des cadres établis de PPP, notamment par l'adoption d'arrangements contractuels formels (prévoyant des mécanismes de responsabilité, des objectifs mesurables définis par les pouvoirs publics et des conséquences exécutoires), afin de mieux aligner ces partenariats avec les objectifs de santé publique. Deuxièmement, sur un plan théorique, elle explore le concept de « dénormalisation sociale » comme outil juridique et social visant à transformer les normes entourant la production et la consommation d'aliments malsains. En s'appuyant sur l'article 5.3 de la Convention-cadre de l'OMS pour la lutte antitabac, elle suggère de dénormaliser les PPP avec l'industrie alimentaire, en recourant à l'adoption de réglementations de type command-and-control au niveau national. Ces mesures seraient susceptibles d'induire des changements significatifs au sein de l'industrie, de façonner les comportements de consommation et de promouvoir véritablement la santé publique ainsi que la prévention des MNT.

Mots-clés: maladies non transmissibles ; partenariats public-privé ; droit de la santé publique ; approches réglementaires ; régimes alimentaires malsains ; industrie alimentaire ; conflit d'intérêts ; promotion de la santé publique ; reformulation des produits ; droit à la santé.

TABLE OF CONTENTS

- ABBREVIATIONS.....15**
- BIBLIOGRAPHY.....21**
- INTRODUCTION..... 63**
 - I Introductory remarks 63
 - II Existing literature and research interest 67
 - III Thesis structure 70
 - IV Methodology 72
- PART 1 SETTING THE SCENE: NON-COMMUNICABLE DISEASES’ CONTEXT AND CHALLENGE.....73**
 - CHAPTER 1: THE GLOBAL BURDEN OF NON-COMMUNICABLE DISEASES 77**
 - I Overview of non-communicable diseases 77
 - 1 Preliminary remarks 77
 - 2 Four main diseases 79
 - 2.1 Cardiovascular disease 79
 - 2.2 Diabetes 81
 - 2.3 Cancer 82
 - 2.4 Chronic respiratory diseases 84
 - 3 Obesity: a growing NCD-related aspect..... 85
 - 4 Key risk factors for NCDs..... 86
 - 4.1 Tobacco 86
 - 4.2 Harmful use of alcohol 89
 - 4.3 Unhealthy diet..... 91
 - 4.4 Physical inactivity..... 97
 - II NCD risk distribution and social determinants of health 98
 - CHAPTER 2: THE NON-COMMUNICABLE DISEASE PANDEMIC AND THE AGENTS RESPONSIBLE FOR CREATING THE RISK FACTORS 101**
 - I The process of globalization and the rise of NCDs in low- and middle-income countries 101
 - 1 Preliminary remarks 101
 - 2 Globalization and trade law 101
 - 3 Nutrition transition to unhealthy diets 103
 - II Risk-creating industries 105
 - 1 Preliminary remarks 105

2 Big Food and Big Soda	106
3 Commercial determinants of health	109
CHAPTER 3: PUBLIC HEALTH, NCD PREVENTION, AND THE LAW	115
I Notion of public health	115
II Public health law	116
1 Definition.....	116
2 Regulatory approaches	117
CONCLUDING REMARKS ON PART 1	118
PART 2 PUBLIC HEALTH LEGAL RESPONSES TO NON-COMMUNICABLE DISEASES PREVENTION.....	121
CHAPTER 4: NORMATIVE FRAMEWORK GOVERNING NCD PREVENTION.....	123
I Preliminary remarks	123
II Global health law	123
III Human rights as a justification underlying NCD prevention.....	125
1 The right to health: normative justification	125
1.1 Historical evolution	125
1.2 Definition and guiding principles of the right to health	128
1.3 Tripartite typology of obligations.....	130
2 Right to adequate food	132
2.1 Definition.....	132
2.2 Tripartite typology of obligations.....	133
2.3 International institutions and the right to adequate food	135
IV Interconnecting regimes that have an impact on human rights: trade law and the right to health.....	136
1 International trade law and public health	136
2 The legal framework for health measures under WTO agreements.....	138
3 Intellectual property and public health legal tools	140
CHAPTER 5: INTERNATIONAL FRAMEWORK	143
I Preliminary remarks	143
II The rise of non-communicable diseases in the global health agenda.....	143
III International law sources	144
IV Binding instruments: WHO Framework Convention on Tobacco Control	147
1 Preliminary remarks	147
2 Article 5.3	148
3 FCTC and trade law	151
V Non-binding instruments.....	151

1 United Nations General Assembly	152
1.1 High-level Meeting on NCDs.....	152
1.2 Sustainable Development Goals	154
2 World Health Assembly	155
2.1 WHO Global Strategies	156
2.2 The WHO Global Action Plan for the Prevention and Control of NCDs	158
2.3 Best Buys.....	161
VI Other relevant initiatives to the prevention of NCDs	163
1 UN Inter-Agency Task Force on the Prevention and Control of NCDs	163
2 WHO NCD Global Monitoring Framework	164
3 Global Coordination Mechanism on the Prevention and Control of NCDs.....	164
CHAPTER 6: THE EUROPEAN UNION’S RESPONSES	167
I Legal competences.....	167
1 EU NCD risk regulation.....	169
2 Categories of policy interventions to prevent and control NCDs	170
II Closer look at the EU public health strategies focused on unhealthy diets.....	171
1 Green Paper on promoting healthy diets and physical activity	172
2 The Obesity Prevention White Paper	172
3 EU Platform on Diet, Physical Activity and Health.....	173
4 Europe’s Beating Cancer Plan.....	176
5 WHO Vienna Declaration on Nutrition and Non-communicable Diseases in the Context of Health 2020	177
III Cross-sectoral legal dimensions of NCD prevention.....	177
1 Agricultural and sustainability policies in the EU and diet-related NCDs.....	177
2 Analysis of the EU nutrition policy through the consumer law and food law lens..	180
CHAPTER 7: DOMESTIC LEVEL.....	185
I Preliminary remarks	185
II Legal tools	185
1 Taxation.....	185
1.1 Public health taxes	185
1.2 Sugar-sweetened beverages taxes.....	187
1.3 Future directions for public health taxes	190
2 Marketing restrictions of unhealthy products.....	191
3 Mandatory front-of-package labelling.....	193
III Case study: Switzerland	195

1 Legal competences	196
2 Soft law initiatives.....	198
3 Legal exceptionalism for public health law	201
CHAPTER 8: PRIVATE RESPONSES	203
I Preliminary remarks	203
II The prevention state and paternalism critique.....	203
1 The nanny state and personal responsibility.....	205
2 Industry tactics against NCD regulation: invoking human rights	207
III Self-regulation.....	209
1 Definition.....	209
2 Examples	212
2.1 EU Pledge	212
2.2 The International Food and Beverage Alliance	214
IV Corporate social responsibility	215
1 Definition.....	215
2 Critiques	217
3 Healthwashing	219
CONCLUDING REMARKS ON PART 2	219
PART 3 PUBLIC-PRIVATE PARTNERSHIPS AS AN INNOVATIVE TOOL?.....	221
CHAPTER 9: TAXONOMY OF PUBLIC-PRIVATE PARTNERSHIPS	225
I Preliminary Remarks	225
II Public-private partnerships in general.....	226
1 Historical Framework.....	227
2 Key characteristics	229
3 Definition.....	231
4 Legal framework	233
III Global health public-private partnerships	238
1 Historical framework.....	238
2 Key characteristics	239
3 Definition.....	242
4 Legal framework	243
5 Examples	245
5.1 Global Alliance for Vaccine and Immunization.....	245
5.2 The Global Fund, to fight AIDS, Tuberculosis, and Malaria	247

5.3 The Stop TB Partnership	248
6 New format of global health public-private partnerships.....	249
IV Comparative analysis: Global health PPPs vis-à-vis the PPPs in general	252
CHAPTER 10: PUBLIC-PRIVATE PARTNERSHIPS FOR NCD PREVENTION	255
I Terminology	255
1 Historical framework.....	255
2 Key characteristics	256
3 Definition.....	265
4 Legal framework	269
II Case studies: public-private partnerships with ultra-processed food and the sweetened beverage industries.....	270
1 Sample Selection	270
2 Public Health Responsibility Deal	272
2.1 Background and form of agreement	272
2.2 Analysis and results	275
2.3 Conclusion	278
3 The Danish Whole Grain Partnership	279
3.1 Background and form of agreement	279
3.2 Analysis and results	281
3.3 Conclusion	282
4 The Declaration of Milan	282
4.1 Background and form of agreement	282
4.2 Analysis and results	284
4.3 Conclusion	288
5 Voluntary Sodium Reduction Goals.....	288
5.1 Background.....	288
5.2 Analysis and results	292
5.3 Conclusion	294
III Nutri-Score: a public scheme voluntarily adopted by industry that falls short of the definition of a PPP for NCD prevention	295
1 Background	295
2 Analysis and Results	296
3 Nutri-Score beyond the scope of PPP for NCD prevention	298
IV Comparative analysis: PPPs for NCD prevention vis-à-vis PPPs in general and global health PPPs.....	299
CHAPTER 11: LEGAL SCRUTINY OF PPPs FOR NCD PREVENTION	303

I Preliminary remarks	303
II The promotion of public health by private actors	304
1 Introduction	304
2 Public-private dichotomy	306
2.1 Blurring boundaries between public and private	307
2.2 The regulatory welfare state and the transformation of public functions	308
2.3 Regulatory capture and the limits of PPPs for NCD prevention	309
3 Spheres Transgression	311
III Conflict of interest	315
1 Definition	315
2 Conflict of interest and private actors within the WHO framework	318
3 Conflict of interest in other areas	319
4 Conflict of interest and NCD prevention	322
IV Lobbying and PPPs for NCD prevention as a regulation avoidance mechanism	326
1 Definition	326
2 Corporate political activity	328
3 Examples	329
CONCLUDING REMARKS ON PART 3	331
PART 4 RETHINKING LEGAL FRAMEWORKS AND PATHWAYS FOWARD FOR PUBLIC-PRIVATE PARTNERSHIPS.....	333
CHAPTER 12: BUILDING ROBUST PPPs FOR NCD PREVENTION	339
I Framework for PPPs for NCD prevention	339
1 Transplanting principles from the UN scope	340
2 Literature	344
3 Human rights principles for the establishment of PPPs	348
3.1 Transparency	348
3.2 Accountability	349
3.3 Due diligence	351
4 Business and human rights framework	353
4.1 Horizontal effect of human rights	355
4.2 Human rights obligation of private actors	357
5 Environmental voluntary agreements	359
6 Social Impact Bonds	360
7 Formal contract	362
7.1 Preliminary remarks	363

7.2 Key elements	363
7.3 Applying the contractual framework to the Swiss context: Declaration of Milan	367
II Conclusion.....	367
CHAPTER 13: DENORMALIZING PPPs AS A REGULATORY TOOL FOR NCD PREVENTION	369
I Preliminary remarks	369
II Social denormalization through regulation	370
1 Normalization and denormalization theory	371
2 Denormalization of Big Food and Big Soda	374
2.1 International level	375
2.2 Denormalizing Big Food and Big Soda at the domestic level: the Swiss Context	378
III Conclusion	380
CONCLUSION.....	383
I Recapitulation of the findings	383
II Closing remarks	390
ANNEX 1.....	397

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ABBREVIATIONS

APC alcohol per capita consumption

Art. article(s)

BMI body mass index

CAP Common Agricultural Policy

CDoH commercial determinants of health

CESCR UN Committee on Economic Social, and Cultural Rights

COI conflict of interest

COP Conference of the Parties

CRDs chronic respiratory diseases

CSR corporate social responsibility

CVD cardiovascular diseases

DALYs disability-adjusted life years

EBCP Europe's Beating Cancer Plan

e.g. *exempli gratia* = for example

EU European Union

FAO Food and Agriculture Organization of the UN

FCTC Framework Convention on Tobacco Control

FDA Food Drug Administration

FDI Foreign Direct Investments

FENSA Framework of Engagement with Non-State Actors

Foodstuffs Act Federal Act on Foodstuffs and Utility Articles of 20 June 2014 (Foodstuffs Act; CC 817.0)

FOP front-of-package

FOPH Swiss Federal Office of Public Health

FOPL front-of-package label

FSVO Swiss Federal Food Safety and Veterinary Office

FTA Free trade agreement

GAIN Global Alliance for Improved Nutrition

GATT General Agreement on Tariffs and Trade of 30 October 1947

GAVI Global Alliance for Vaccine and Immunization

GCM/NCD Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases

GDP gross domestic product

GPPPs global health public-private partnerships

HFSS high in fats, sodium or sugar

ICC International Chamber of Commerce

ICCPR International Covenant on Civil and Political Rights, opened for signature 16 December 1966 and entered into force 23 March 1976

ICESCR International Covenant on Economic, Social and Cultural Rights, opened for signature 16 December 1966 and entered into force 3 November 1976

ICJ International Court of Justice

IFBA International Food & Beverage Alliance

IP intellectual property

LMICs low and middle-income countries

NAFTA North American Free Trade Agreement

NCD GAP Global Action Plan for the Prevention and Control of Non-Communicable Diseases

NCD noncommunicable disease

NCDs noncommunicable diseases

NGOs nongovernmental organizations

NPM new public management

NSRI New York City Health Department launched the National Salt Reduction Initiative

OECD Organization for Economic Co-operation and Development

OHCHR Office of the United Nations High Commissioner for Human Rights

PPE public-private engagement

PPP public-private partnership

RD responsibility deal

SCN Standing Committee on Nutrition

SDGs Sustainable Development Goals

SDH social determinants of health

SIBs social impact bonds

SPS Agreement WTO Agreement on Sanitary and Phytosanitary Standards, entered into force on 1 January 1995

SSBs sugar-sweetened beverages

SUN Scaling Up Nutrition

TB tuberculosis

TBT Agreement WTO Agreement on Technical Barriers to Trade, entered into force on 1 January 1995

TFEU Treaty on the Functioning of the European Union

TRIPS Agreement Trade-Related Aspects of Intellectual Property Rights

UDHR Universal Declaration of Human Rights of 10 December 1948

UK United Kingdom of Great Britain and Northern Ireland

UN United Nations

UNCITRAL United Nations Commission on International Trade Law

UNECE United Nations Economic Commission for Europe

UNGA United Nations General Assembly

UNGPs United Nations Guiding Principles on Business and Human Rights

UNHRC United Nations Human Rights Council

UNICEF United Nations Children's Fund

UNSDG UN Sustainable Development Group

UPFs ultra-processed food

US United States of America

USAID United States Agency for International Development

VAT value added tax

WFP World Food Programme

WHA World Health Assembly

WHO World Health Organization

WTO World Trade Organization

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INTRODUCTION

I Introductory remarks

The increase and the burden of non-communicable diseases (NCDs), which are represented mostly by cardiovascular disease, diabetes, cancer, and chronic respiratory diseases, have gained attention in the public health field. According to the World Health Organization (WHO), non-communicable diseases killed at least 43 million people in 2021, equivalent to 75% of non-pandemic-related deaths globally.¹ Moreover, non-communicable diseases are not only a problem in high-income countries anymore. Due to the process of globalization, 73% of all NCD deaths are in low and middle-income countries (LMICs).² As a response, States and International Organizations such as the WHO have been adopting different legal measures to fight this “silent pandemic”.³

Non-communicable diseases are driven by a complex interplay of behavioral, metabolic, and environmental risk factors.⁴ Among the key behavioral risk factors identified by the WHO are tobacco use, harmful alcohol consumption, unhealthy diets high in saturated and trans fats, salt, and sugar (particularly from sugar-sweetened beverages), and physical inactivity.⁵ These factors are classified as “modifiable behavioral risk factors” since they are related to human behavior and lifestyle.⁶ From the factors mentioned above, tobacco is responsible for over 7.2 million deaths per year, excess salt/sodium intake accounts for 4.1 million deaths a year, and insufficient physical activity represents 1.6 million annual deaths.⁷ It is estimated that 40–50% of the premature mortality caused by NCDs could be prevented by managing the risk factors.⁸

In addition, these behavioral risk factors contribute to four critical metabolic changes that heighten the risk of developing NCDs: raised blood pressure (including hypertension), overweight and obesity, high blood glucose levels (including diabetes), and abnormal blood lipids (including high cholesterol).⁹

¹ World Health Organization, ‘Noncommunicable Diseases’ (WHO 2024) <<https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases>> accessed 1 April 2025.

² *ibid.*

³ Lawrence O Gostin, *Global Health Law* (Harvard University Press, 2014) 25.

⁴ WHO, ‘Noncommunicable Diseases’ (n 1).

⁵ *ibid.*

⁶ *ibid.*

⁷ *ibid.*

⁸ K Srinath Reddy and Manu Raj Mathur, ‘Global Burden of CVD’ in Robin Haring and others (eds), *Handbook of Global Health* (Springer 2021).

⁹ WHO, ‘Noncommunicable Diseases’ (n 1).

Beyond behavioral and metabolic factors, environmental conditions play a significant role in the global burden of NCDs. Indoor and outdoor air pollution is the most substantial environmental risk factor, accounting for an estimated 6.7 million deaths worldwide.¹⁰

Due to its relevance, non-communicable diseases have been part of the WHO agenda and are part of the UN Sustainable Development Goals. Specifically, target 3.4 is to reduce by 2030 one-third of premature mortality from non-communicable diseases through prevention and treatment.¹¹ In addition, at the domestic level, the prevention of NCDs is a topic that states pay attention to due to the rising healthcare costs and economic development. For instance, in Switzerland, the NCDs represent 80% of healthcare costs; in 2011, the expenses amounted to almost 52 billion francs.¹²

For these reasons, NCDs have also become a pressing priority on global and domestic legal agendas.¹³ Given that NCDs are largely preventable, increasing attention has been directed toward the regulation of their associated risk factors.¹⁴ Public health legal measures to tackle non-communicable diseases are traditionally represented by command-and-control regulations such as taxation and restrictions on tobacco, alcohol, and fast-food advertising.¹⁵ However, these measures have implications for the population's lifestyle and juxtapose the balance between collective and individual rights.¹⁶ As a result, these regulatory efforts are frequently criticized for their perceived paternalism, earning labels like the “nanny state”.¹⁷

In addition to these critiques, the reliance on the expertise of private actors and the perceived “need” to involve transnational corporations have led States to adopt public-private partnerships (PPPs) through voluntary agreements as an alternative regulatory approach to NCD prevention.

¹⁰ *ibid.*

¹¹ United Nations, ‘SDG Indicators’ (*UNSTATS*) <<https://unstats.un.org/sdgs/metadata?Text=&Goal=3&Target=3.4>> accessed 12 May 2022.

¹² Office Fédéral de la Santé Publique, *Faits et Chiffres: Maladies Non Transmissibles* <<https://www.bag.admin.ch/fr/faits-et-chiffres-maladies-non-transmissibles>> accessed 12 May 2022.

¹³ Brigit Toebe and others, ‘Curbing the Lifestyle Disease Pandemic: Making Progress on an Interdisciplinary Research Agenda for Law and Policy Interventions’ (2017) 17 *BMC International Health and Human Rights* 25.

¹⁴ Alberto Alemanno and Amandine Garde, ‘Chapter 1: Regulating Lifestyles: Europe, Tobacco, Alcohol and Unhealthy Diets’ in Alberto Alemanno and Amandine Garde (eds), *Regulating Lifestyle Risks: The EU, Alcohol, Tobacco and Unhealthy Diets* (Cambridge University Press 2015).

¹⁵ Lawrence O Gostin ‘Chapter 13: the “Silent” Pandemic of Noncommunicable Diseases’ in Lawrence O Gostin, *Global Health Law* (Harvard University Press, 2014).

¹⁶ Marie-Hélène Peter-Spiess, *Food Regulation and Public Health: The Case off Sugar* (Schulthess 2024) 91.

¹⁷ Alemanno and Garde, ‘Chapter 1: Regulating Lifestyles: Europe, Tobacco, Alcohol and Unhealthy Diets’ (n 14) 2; Roger S Magnusson, ‘Case Studies in Nanny State Name-Calling: What Can We Learn?’ (2015) 129 *Public Health* 1074.

Public-private partnerships in the context of health are not new. The narrative that the private sector must be engaged in dealing with complex health challenges started with the global health PPPs in the late 1990s and early 2000s, although they predominantly focused on infectious diseases.¹⁸ Their main goal has been to provide low-income countries access to new medications and vaccines.¹⁹

Over the years, there has been a significant incentive for public-private partnerships at the international and domestic levels. Public-private partnerships have been encouraged by the UN and the WHO.²⁰ In September 2011, the first Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases was published. There is a sector called international cooperation, including collaborative partnerships, which incite engagement with the private sector through partnerships to promote healthy diets and lifestyles.²¹

PPP are also part of the United Nations Sustainable Development Goals (SDGs). Specifically, target 17.17 is to “encourage and promote effective public, public-private, and civil society partnerships, building on the experience and resourcing strategies of partnerships”.²²

Public-private partnerships evolved to target non-communicable diseases. In 2011, the United Kingdom created the Public Health Responsibility Deal (RD), a public-private partnership focused on unhealthy diets, alcohol consumption, physical activity, and behavior change through voluntary agreements.²³ Likewise, there are public-private partnerships for the promotion of physical activity, for instance, Brazil’s Agita São Paulo Program, or more specifically, PPPs for childhood obesity, such as Michelle Obama’s initiative “Let’s Move!” in the United States.²⁴

¹⁸ See Part 3, Chapter 9, III Global health public-private partnerships.

¹⁹ *ibid.*

²⁰ See Part 2, Chapter 5, V.

²¹ UN General Assembly, ‘Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases : draft resolution / submitted by the President of the General Assembly’ (16 September 2011) UN Doc A/RES/66/2. “54. Engage non-health actors and key stakeholders, where appropriate, including the private sector and civil society, in collaborative partnerships to promote health and to reduce non-communicable disease risk factors, including through building community capacity in promoting healthy diets and lifestyles”.

²² United Nations, ‘Goal 17: Revitalize the Global Partnership for Sustainable Development’ (United Nations Sustainable Development 2023) <<https://www.un.org/sustainabledevelopment/globalpartnerships/>> accessed 2 March 2022.

²³ Part 3, Chapter 10, II, 2 Public Health Responsibility Deal.

²⁴ Portal Agita <<https://www.portalagita.org.br/>> accessed 3 August 2022; Let’s Move! <<https://letsmove.obamawhitehouse.archives.gov/>> accessed 3 August 2022.

The definition of public-private partnerships in the context of NCDs is not straightforward, considering that these collaborations can take different formats.²⁵ The interaction between the public and the private sector for public health promotion and prevention of non-communicable diseases differs from “traditional” models of global health public-private partnerships because there is no organizational structure with a board, rules, and staff, for instance, the GAVI Alliance.²⁶ The PPPs in the NCD framework can involve funding from the private to the public or vice versa. However, some interactions do not involve funding and are seen as “educational campaigns”, which include goals defined by the public sector for the private sector to accomplish, such as salt reduction initiatives.²⁷

There is a lack of definitions, norms, and guidelines for these types of collaborations with the food industry in the context of NCDs. A major obstacle to this approach is that these private actors, by selling their unhealthy products, create the risk for obesity, diabetes, and other diet-related NCDs. Additionally, scholars argue that transnational corporations aim to maximize their profit without considering public health goals, and that corporations will never deliberately and fully engage in efforts that threaten their financial viability.²⁸

In NCD prevention, despite some progress in areas such as tobacco control, the food industry has received different legal treatment at the international, regional, and domestic levels. This distinctive approach is often attributed to the greater regulatory challenges it presents, since food is a fundamental necessity.²⁹

The conflict of interest posed by the tobacco industry is widely acknowledged, given the well-documented history of its lobbying efforts and their harmful influence on public health policy.³⁰ Consequently, Art. 5.3 of the WHO Framework Convention on Tobacco Control states the “non-engagement with the tobacco industry”.³¹

²⁵ Corinna Hawkes and Kent Buse, ‘Public Health Sector and Food Industry Interaction: It’s Time to Clarify the Term “Partnership” and Be Honest about Underlying Interests’ (2011) 21 *The European Journal of Public Health* 400.

²⁶ Gian Luca Burci, ‘Public/Private Partnerships in the Public Health Sector’ (2009) 6 *International Organizations Law Review* 359.

²⁷ Hawkes and Buse, ‘Public Health Sector and Food Industry Interaction’ (n 25).

²⁸ David Stuckler and Marion Nestle, ‘Big Food, Food Systems, and Global Health’ (2012) 9 *PLoS Medicine*; Luke N Allen, ‘Commercial Determinants of Global Health’ in Robin Haring and others (eds), *Handbook of Global Health* (Springer 2020).

²⁹ Bryan Thomas and Lawrence O Gostin, ‘Tackling the Global NCD Crisis: Innovations in Law and Governance’ (2013) 41 *The Journal of Law, Medicine & Ethics* 16.

³⁰ Kelly D Brownell and Kenneth E Warner, ‘The Perils of Ignoring History: Big Tobacco Played Dirty and Millions Died. How Similar Is Big Food?’ (2009) 87 *Milbank Quarterly* 259.

³¹ WHO Framework Convention on Tobacco Control (adopted 21 May 2003, entered into force 27 February 2005) 2302 UNTS 166 art 5.3.

Therefore, the question is whether voluntary collaborations with the so-called “major drivers of the non-communicable disease epidemic,” such as Big Food and Big Soda, can be considered a viable legal tool. Moreover, there are several concerns about PPPs for NCD prevention achieving their goals. For instance, the “Public Health Responsibility Deal” has not effectively achieved the stated public health goals.³²

Despite that, an argument to support the public-private partnerships with the food and beverage companies is that without their cooperation and expertise (on their unhealthy products!), tackling non-communicable diseases will be more difficult.³³ Therefore, there is a perceived “need” of their engagement to find a solution. Likewise, one point of view raised is that at least there is a movement from transnational companies with the reformulation of ultra-processed food to either reduce or remove salt, saturated fats, added sugars, and trans-fat.³⁴

Public-private partnerships for NCD prevention with the food industry are an alternative tool to traditional regulation that raises many questions. In addition, these collaborations operate in a legal gray zone. There are no regulations or guidelines for these interactions or even a consensus about the definition. Hence, this thesis’s overall objective is to analyze from a legal perspective the public-private partnerships with the food and sweetened beverage industries in the context of non-communicable disease prevention, focused on product reformulation.

II Existing literature and research interest

There is an increasing academic reflection on the concerns associated with voluntary collaborations with the food industry in the context of unhealthy diets.³⁵ However, most authors concentrate on the non-legal aspects.

³² Cécile Knai and others, ‘The Public Health Responsibility Deal: Using a Systems-Level Analysis to Understand the Lack of Impact on Alcohol, Food, Physical Activity, and Workplace Health Sub-Systems’ (2018) 15 *International Journal of Environmental Research and Public Health* 2895.

³³ Stuckler and Nestle, ‘Big Food, Food Systems, and Global Health’ (n 28).

³⁴ Ellis L Vyth and others, ‘Front-of-Pack Nutrition Label Stimulates Healthier Product Development: A Quantitative Analysis’ (2010) 7 *International Journal of Behavioral Nutrition and Physical Activity* 65; Rob Moodie and others, ‘Profits and Pandemics: Prevention of Harmful Effects of Tobacco, Alcohol, and Ultra-Processed Food and Drink Industries’ (2013) 381 *The Lancet* 670.

³⁵ See for example: Dori Patay and others, ‘Fifty Shades of Partnerships: A Governance Typology for Public Private Engagement in the Nutrition Sector’ (2023) 19 *Globalization and Health*.; Moodie and others, ‘Profits and Pandemics’ (n 34); Jonathan H Marks, ‘Toward a Systemic Ethics of Public–Private Partnerships Related to Food and Health’ (2014) 24 *Kennedy Institute of Ethics Journal* 267; Kent Buse, Sonja Tanaka and Sarah Hawkes, ‘Healthy People and Healthy Profits? Elaborating a Conceptual Framework for Governing the Commercial Determinants of Non-Communicable Diseases and Identifying Options for Reducing Risk Exposure’ (2017) 13 *Globalization and Health*; Eric Crosbie and Angela Carriedo, ‘Applying a Commercial Determinants of Health Lens to Understand, Expose and Counter Industry Co-Option, Appeasement and Partnership; Comment on “Part

Moreover, the public-private dichotomy keeps reemerging.³⁶ In the scenario of PPPs for NCD prevention, critical questions arise: are private actors' part of the solution to non-communicable diseases? Or, in other words, should they be part of the solution? These issues require rigorous legal scrutiny and careful examination of the public-private dichotomy within such partnerships.

This thesis thus examines PPPs for NCD prevention through a legal lens. As already noted, "NCD law" is not a distinct branch of law, and NCD prevention interacts with various areas of law.³⁷ Therefore, drawing on global health law, public health law, and business and human rights frameworks, the thesis sheds light on the legal nature and the limitations of PPPs as an alternative regulatory tool for NCD prevention. It is important to highlight that a rights-based approach is used to guide this study.³⁸ This project aims to understand the current role of PPPs for NCD prevention and to explore how legal frameworks can shape and guide these partnerships to better serve public health objectives, ultimately informing how the law might restructure them for the future.

The central questions guiding this study are: How did public-private partnerships with the food and sweetened beverage industries emerge as an alternative regulatory approach for NCD prevention? What is the definition of PPPs for NCD prevention, and how does it differ from traditional PPPs and global health PPPs? To what extent can PPPs function as an appropriate legal tool in this context, and what legal frameworks or safeguards are necessary to adapt them to better serve public health objectives?

For the purposes of this study, the terms food industry, ultra-processed food industry, food companies, transnational food companies, and risk-creating industries will be used

of the Solution:’ Food Corporation Strategies for Regulatory Capture and Legitimacy” (2022) 11 International Journal of Health Policy and Management; Jennifer Lacy-Nichols and Owain Williams, “Part of the Solution:” Food Corporation Strategies for Regulatory Capture and Legitimacy’ (2021) 10 International Journal of Health Policy and Management.

³⁶ Hila Shamir, ‘The Public/Private Distinction Now: The Challenges of Privatization and of the Regulatory State’ (2014) 15 Theoretical Inquiries in Law.

³⁷ Amandine Garde, ‘Chapter 13: Global Health Law and Non-Communicable Disease Prevention: Maximizing Opportunities by Understanding Constraints’ in Gian Luca Burci and Brigit Toebes (eds), *Research Handbook on Global Health Law* (Edward Elgar Publishing 2018) 423.

³⁸ A rights-based approach has been recognized as an important framework for NCD prevention. See for example: Brigit Toebes and David Patterson, ‘Human Rights and Non-Communicable Diseases – Controlling Tobacco and Promoting Healthy Diets’ in Lawrence O Gostin and Benjamin Mason Meier (eds), *Foundations of Global Health & Human Rights* (Oxford University Press 2020); Laura Ferguson and others, ‘Non-Communicable Diseases and Human Rights: Global Synergies, Gaps and Opportunities’ (2016) 12 Global Public Health 1200; Andrés Constantin and others, ‘A Human Rights-Based Approach to Non-Communicable Diseases: Mandating Front-of-Package Warning Labels’ (2021) 17 Globalization and Health; Garde, ‘Global Health Law and Non-Communicable Disease Prevention’ (n 37).

interchangeably.³⁹ In addition, the terms “corporation”, “companies”, “industries,” and “business enterprises” will be employed as synonyms.⁴⁰

Defining what constitutes a “risk-creating industry” presents conceptual challenges and limitations. In practice, many companies operate across a spectrum of products, selling products that can be considered harmful to health and products that are not. Within the scope of this research, the term risk-creating industries refers to those companies whose core business model, dominant sales, or product portfolios are centered on ultra-processed foods or, more broadly, unhealthy food products.⁴¹ A working example would be companies in which the majority of their food portfolio consists of products considered “unhealthy food”, contributing to diet-related NCD risks.⁴²

This research contributes to the field by offering an in-depth analysis of these voluntary collaborations with the food industry as alternative regulatory tools for NCD prevention. It develops a taxonomy to clarify the definition of such partnerships within the broader context of PPPs, while exploring a selection of case studies. The case selection is based on a comprehensive literature review of PPPs within the NCD context, with a particular focus on reformulation strategies.⁴³ Food reformulation was chosen as a central lens because it is regarded as a promising public health intervention that seeks to achieve industry-level change, rather than merely targeting individual behavior. Moreover, many countries continue to rely on voluntary approaches to encourage reformulation, making it a critical area for examining the potential and limitations of PPPs as an alternative regulatory tool to stricter regulation in addressing unhealthy diets and NCD prevention.

Finally, as this research is part of the Swiss National Science Foundation Eccellenza Project “The Increasing Weight of Regulation: The Role(s) of Law as a Public Health Tool in the Prevention State”, it provides recommendations on possible future reforms to the law in Switzerland.

³⁹ Jennifer Lacy-Nichols and others, ‘Conceptualising Commercial Entities in Public Health: Beyond Unhealthy Commodities and Transnational Corporations’ (2023) 401 *The Lancet*.

⁴⁰ OECD, ‘Concepts and Principles’ in OECD, *Guidelines for Multinational Enterprises on Responsible Business Conduct* (OECD 2023) art 4. A precise definition of corporations or multinational enterprises is not required for the purposes of this thesis. As the OECD guidelines establish, “multinational enterprises operate in all sectors of the economy.”

⁴¹ For a better understanding of unhealthy food and UPFS see Part 1, Chapter 1, 4.3 Unhealthy diet.

⁴² Judith Evans, ‘Nestlé Document Says Majority of Its Food Portfolio Is Unhealthy’ (*Financial Times* 2021) <<https://www.ft.com/content/4c98d410-38b1-4be8-95b2-d029e054f492>> accessed 27 June 2025.

⁴³ See Part 3, Chapter 10, II, 1 for a detail explanation.

III Thesis structure

In order to answer the research question, the present thesis is structured in four parts. Part 1 aims to establish the importance of legally addressing non-communicable diseases. It does this by providing a background of the burden of NCDs, presenting the key risk factors for developing the diseases, and discussing the economic and social burden of NCDs, with a focus on unhealthy diets. In addition, it exposes the actors involved in the public-private partnerships, presenting the concept of commercial determinants of health to explore deeper in the following chapters the challenges and potentials of this approach as a response to tackle NCDs. It finishes by introducing the field of public health law and the regulatory approaches in the NCD scenario.

Part 2 addresses the second part of the question on how public-private partnerships with the food and sweetened beverage industries emerged as an alternative regulatory approach for NCD prevention. It begins with the normative framework exploring the right to health and its justification to better understand the state's obligation to prevent NCDs. Subsequently, it will map the legal instruments concerning NCD prevention to understand how the existing legal framework enabled the development of PPPs in this context. From an international perspective, it will present and analyze the treaties and conventions at the UN level, and the WHO, such as the Global Strategy for the Prevention and Control of Noncommunicable Diseases (2000), the Global Strategy on Diet, Physical Activity, and Health (2008), and other soft law instruments. Although the focus of this thesis is the food and sweetened beverage industries, it is imperative to look into the WHO Framework Convention on Tobacco Control (FCTC) as an important model for the limits of the private sector activity. Next, at the regional level, it will present the responses at the European level, which translates the same idea from the international scenario of a soft law approach. Later, it explores the public health measures imposed by the States, exploring the current legal tools adopted in different countries, which include a mix of command-and-control and voluntary approaches. Afterward, it presents the development of the "new governance" to regulatory approaches and the paternalism criticism of stricter legal tools, and how this framework made it possible for industries to picture themselves as part of the solution. Thus, a brief analysis of private responses, such as self-regulation and corporate social responsibility, will be addressed.

Part 3 will dive into the topic of public-private partnerships. It will begin with a taxonomy of the term, examining public-private partnerships in general, their definitions, types, and how perceptions of government inefficiency, along with the rise of "new public management" approaches, contributed to their emergence. In the public health context, from a historical

perspective, it will present the shift of public-private partnerships from exclusively tackling infectious diseases to tackling non-communicable diseases. Next, it will adopt a definition for PPPs for NCD prevention and address case studies of PPPs with the food and sweetened beverage industry focused on product reformulation to illustrate the diversity of types of these collaborations. Finally, it will subject such partnerships to legal scrutiny, from foundational questions about the role of private actors in advancing public health to practical issues like conflicts of interest and the lobbying for PPPs for NCD prevention as a regulation avoidance mechanism. This part addresses three aspects of the research question. First, it continues to contextualize how these partnerships emerged as an alternative regulatory tool to command-and-control regulation. Second, it offers a definition of PPPs for NCD prevention, situating them within the taxonomy of traditional PPPs and global health PPPs, and highlighting how they differ. Third, it examines the extent to which they can function as an appropriate legal tool for NCD prevention.

Part 4 addresses the last part of the research question. It aims to identify the legal frameworks and safeguards necessary to adapt PPPs for NCD prevention so they can better serve public health objectives. To this end, it advances two main hypotheses for pathways forward concerning PPPs for NCD prevention. The first hypothesis suggests that as private entities have become increasingly involved in providing public goods, PPPs are expanding into diverse fields, including collaborations with the food industry for NCD prevention and public health promotion. However, the challenge lies in establishing a robust framework that addresses human rights principles, such as accountability and transparency, and includes stringent compliance mechanisms. Thus, to provide the safeguards necessary to adapt PPPs for NCD prevention, this hypothesis suggests that adapting legal elements from established PPP frameworks may offer pathways to more effective collaborations in the public health domain. It suggests the adoption of a formal contractual framework.

The second hypothesis takes a critical theoretical perspective, arguing that the inherent conflicts of interest within the food industry undermine public health objectives, particularly given that these companies are the risk creators for obesity, diabetes, and other NCDs through their unhealthy products. Thus, it is imperative to challenge the current legal architecture for NCD prevention. Taking the regulatory approach toward the tobacco industry as an analogous example, this hypothesis understands the need to derominalize PPPs for NCD prevention with the food industry as an alternative regulatory tool. This part explores the concept of “social

denormalization” as a legal and social tool to shift norms around unhealthy food production and consumption, aiming to reduce industry influence on public health agendas.

IV Methodology

In terms of methodology, this thesis will first adopt a doctrinal analysis.⁴⁴ It analyzes domestic and international legislation, reports, and legal literature. It focused on identifying and examining the legal initiatives and frameworks for NCD prevention. Doctrinal analysis, via primary and secondary sources, provides a foundational understanding of the current legal architecture for NCD prevention, serving as the basis for this study.

The thesis also integrates evaluative methodology, offering a critical assessment of the role of PPPs in promoting health, in particular, whether PPPs for NCD prevention are an appropriate tool for NCD prevention.⁴⁵

Despite its legal character, this thesis adopts an interdisciplinary approach, which has been recognized as key in NCD prevention.⁴⁶ Therefore, this research incorporates scholarly contributions from fields such as medicine, nutrition, behavioral science, and political science. This interdisciplinary dimension supplements the legal evaluation and enables a holistic understanding of the risks and opportunities associated with PPPs for NCD prevention as an alternative legal tool to stricter regulation. Through this lens, the thesis explores how scientific and medical evidence can inform legal concepts and arguments, contributing to a more nuanced examination of the interplay between law and public health.⁴⁷

By combining doctrinal, evaluative, and interdisciplinary approaches, this thesis aims to comprehensively legally analyze public-private partnerships as an alternative regulatory approach to command-and-control regulations for addressing NCDs. This multifaceted methodology underscores the complexities of NCD prevention and PPPs in this context, critically examining their potential as an alternative tool to regulation to either advance or undermine public health objectives.

⁴⁴ Ian Dobinson and Francis Johns, ‘Chapter 1: Legal Research as Qualitative Research’ in Michael McConville and Wing Hong Chui (eds), *Research Methods for Law* (Edinburgh University Press 2017) 20-21.

⁴⁵ Lina Kestemont, *Handbook on Legal Methodology: From Objective to Method* (Intersentia 2018) 17.

⁴⁶ Toebes and others, ‘Curbing the Lifestyle Disease Pandemic’ (n 13).

⁴⁷ Scott Burris and others, ‘Making the Case for Laws That Improve Health: A Framework for Public Health Law Research’ (2010) 88 *Milbank Quarterly* 169.

Finally, as part of the Swiss National Science Foundation Eccellenza Project “The Increasing Weight of Regulation: The Role(s) of Law as a Public Health Tool in the Prevention State”, the project will apply a prospective and normative method to formulate recommendations for possible future law reform in Switzerland.⁴⁸ For example, the adoption of a formal contractual framework for public-private partnerships with the food and beverage industry for NCD prevention, as well as normative proposals to denormalize these PPPs as an alternative regulatory tool at the international and domestic level.⁴⁹

⁴⁸ Kestemont, *Handbook on Legal Methodology* (n 45) 63.

⁴⁹ Scott Burris and others, ‘Better Health Faster’ (2016) 131 *Public Health Reports* 747.

PART 1

SETTING THE SCENE: NON-COMMUNICABLE DISEASES' CONTEXT AND CHALLENGES

CHAPTER 1: THE GLOBAL BURDEN OF NON-COMMUNICABLE DISEASES

I Overview of non-communicable diseases

1 Preliminary remarks

On a global scale, NCDs were responsible for 42.0 million deaths in 2019. Of these, 7.9 million were related to NCDs attributable to dietary risks, while in 1990, this number was 5.4 million. In the European Union, NCDs are responsible for 90% of all deaths. Forty percent of deaths are due to cardiovascular diseases, 26% to cancer, 5% to chronic respiratory diseases, and 2% to diabetes mellitus.⁵⁰

A critical measurement for the disease burden is the disability-adjusted life years (DALYs). The WHO defines DALY as: “*One DALY represents the loss of the equivalent of one year of full health. DALYs for a disease or health condition are the sum of the years of life lost to due to premature mortality and the years lived with a disability due to prevalent cases of the disease or health condition in a population.*”⁵¹ In 2019, the DALYs of NCDs were 187.7 million.⁵² Moreover, the DALYs from diabetes increased by more than 80% between 2000 and 2019.⁵³

According to the Organization for Economic Co-operation and Development (OECD), non-communicable diseases represent more than 550,000 premature deaths of working people in the European Union. This corresponds to a loss of 3.4 million potential productive life years, or ERU 115 billion per year (0.8% of the EU GDP).⁵⁴

In Switzerland, non-communicable diseases are currently the leading cause of death, responsible for over 55,000 deaths each year, accounting for more than four out of five deaths.⁵⁵

⁵⁰ Désirée Vandenberghe and Johan Albrecht, ‘The Financial Burden of Non-Communicable Diseases in the European Union: A Systematic Review’ (2019) 30 *European Journal of Public Health*.

⁵¹ World Health Organization, ‘Disability-Adjusted Life Years (DALYs)’ (*WHO* 2021) <<https://www.who.int/data/gho/indicator-metadata-registry/imr-details/158>> accessed 25 July 2022.

⁵² Jie Qiao and others, ‘Global Burden of Non-Communicable Diseases Attributable to Dietary Risks in 1990–2019’ (2021) 35 *Journal of Human Nutrition and Dietetics*.

⁵³ World Health Organization, ‘Global Health Estimates: Leading Causes of DALYs’ (*WHO* 2022) <<https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/global-health-estimates-leading-causes-of-dalys>> accessed 25 July 2022.

⁵⁴ OECD, European Union, ‘Joint Statement on “Improving the Employment of People with Chronic Diseases in Europe”’ [2017] *Health at a Glance: Europe 2016*.

⁵⁵ OFSP, *Faits et chiffres: Maladies non transmissibles* (n 12).

Approximately 2.2 million people are affected by NCDs, and they account for more than 50% of premature deaths (before the age of 70) in men and more than 60% in women in the country.⁵⁶

In the American region, 5.5 million deaths are caused by NCDs.⁵⁷ For instance, in the United States, diseases such as heart disease, cancer, and diabetes are the primary causes of death and disability. Furthermore, these diseases are key contributors to the nation's annual healthcare expenses, which total \$4.5 trillion.⁵⁸ These statistics underscore a shared global challenge, as many countries are grappling with the high costs and death rates associated with NCDs.

Non-communicable diseases represent high costs to healthcare systems. Through a cost-of-illness approach, the costs of NCDs include direct costs (medical costs, non-medical costs) and indirect costs.⁵⁹ Medical costs are the cost of medical procedures and services associated with the treatment and care of diseases, for instance, hospitalization, outpatient visits, and prescription drugs.⁶⁰ Non-medical costs include the costs of transportation for treatment and care.⁶¹ The indirect costs are also called invisible costs, which are related to lost productivity and income due to disability or death.⁶² Thus, the economic burden of NCDs also adds importance to preventive measures.

The World Economic Forum has described NCDs as one of the main threats to development worldwide since they increase healthcare costs and also represent disability.⁶³ According to a study published in 2011, through an economic growth approach, the world will lose \$30 trillion by 2030 in the treatment of NCDs, representing 48% of global gross domestic product GDP.⁶⁴ Consequently, this will push millions of people below the poverty line.

Non-communicable diseases have been the major cause of mortality for many years. The Coronavirus pandemic has also shown that people who suffer from NCDs were affected harshly by the virus, developing severe cases of the disease and with a higher risk of dying. According

⁵⁶ *ibid.*

⁵⁷ Pan American Health Organization, 'Noncommunicable Diseases' (*PAHO* 2022) <<https://www.paho.org/en/topics/noncommunicable-diseases>> accessed 14 January 2025.

⁵⁸ U.S Centers for Disease Control and Prevention, 'About Chronic Diseases' (*CDC* 2024) <<https://www.cdc.gov/chronic-disease/about/index.html>> accessed 14 January 2025.

⁵⁹ David E Bloom and others, *The Global Economic Burden of Noncommunicable Diseases* (World Economic Forum 2011).

⁶⁰ *ibid.*

⁶¹ *ibid.*

⁶² *ibid.*

⁶³ Shobana Kamineni, 'Why the 21st Century's Biggest Health Challenge Is Our Shared Responsibility' (*WeForum* 2019) <<https://www.weforum.org/stories/2019/01/why-the-21st-century-s-biggest-health-challenge-is-our-shared-responsibility/>> accessed 12 August 2022.

⁶⁴ David E Bloom and others, *The Global Economic Burden of Noncommunicable Diseases* (n 59).

to an infographic published by the WHO and the UNDP, in France, people with obesity were seven times more likely to develop severe coronavirus cases.⁶⁵ Moreover, patients with chronic obstructive pulmonary disease were at a higher risk of severe complications and death from coronavirus.⁶⁶ In many countries, once the COVID-19 vaccine was available, people with NCDs were given priority in getting vaccinated.

2 Four main diseases

Non-communicable diseases are also known as chronic diseases and non-infectious diseases. The four major NCDs are cardiovascular diseases (CVD), cancer, diabetes, and chronic respiratory diseases. These diseases are not transmissible and are developed due to a combination of genetic, physiological, lifestyle, and environmental factors.⁶⁷ There have been a lot of discussions about including mental illness as a non-communicable disease. The UN High-Level Meeting on NCDs, held in September of 2018, committed to promoting mental health and well-being, expanding the big four NCDs and risk factors to a five-by-five approach.⁶⁸

2.1 Cardiovascular disease

Cardiovascular diseases are defined as a group of disorders of the heart and blood vessels.⁶⁹ They include coronary heart disease (also called ischemic heart disease), heart rhythm problems (arrhythmias), heart attacks, strokes, etc.⁷⁰ Heart attacks and strokes result from a blockage that prevents blood from flowing to the heart or brain, mainly due to the buildup of fatty deposits on the inner walls of the blood vessels that supply the heart or brain.⁷¹

⁶⁵ United Nations Development Programme, 'Responding to Non-Communicable Diseases during and beyond the COVID-19 Pandemic' (2020).

⁶⁶ *ibid.*

⁶⁷ WHO, 'Noncommunicable Diseases' (n 1).

⁶⁸ UN General Assembly, 'Political declaration of the 3rd High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases : resolution / adopted by the General Assembly' UN GAOR, 73rd Session Supp. N° 49 UN A/RES/73/2 (17 October 2018). This thesis recognizes the importance of the inclusion of mental illness in the major groups of NCDs; however, as this research's main focus is the risk factor of unhealthy diets. It will not explore this topic further.

⁶⁹ World Health Organization, 'Cardiovascular Diseases (CVDs)' (WHO 2021) <[https://www.who.int/news-room/fact-sheets/detail/cardiovascular-diseases-\(cvds\)](https://www.who.int/news-room/fact-sheets/detail/cardiovascular-diseases-(cvds))> accessed 2 August 2022.

⁷⁰ *ibid.*

⁷¹ *ibid.*

Besides the genetic factors, lifestyle is directly related to the risks of developing heart diseases. The primary risk factor is high blood pressure (also called hypertension), which can be increased, among other things, by smoking, physical inactivity, high consumption of alcohol, and eating too much salt.⁷² In addition, unhealthy cholesterol levels contribute to CVDs.⁷³ Diabetes and obesity are also considered health conditions that increase the risk of heart disease.⁷⁴

Thus, the key risk factors for developing these diseases are tobacco use, an unhealthy diet high in saturated fats, trans fats, and cholesterol, harmful use of alcohol, and physical inactivity.⁷⁵

According to the WHO, CVDs account for most deaths worldwide each year.⁷⁶ In 2019, nearly 17.9 million people died from cardiovascular diseases, and 85% were specifically heart attack and stroke.⁷⁷ Also, in 2019, 38% of the 17 million premature deaths (under the age of 70) of non-communicable diseases were caused by cardiovascular diseases.⁷⁸ Cardiovascular diseases are also the leading cause of mortality in almost all EU countries. In 2013, they represented 40% of all deaths in Europe.⁷⁹ In Switzerland, cardiovascular diseases are the leading cause of death and the third most common cause of hospitalization, with high blood pressure and elevated cholesterol among the main risk factors.⁸⁰

According to the Global Burden of Disease, CVDs are increasing throughout the world. In 1990, the incidence of CVD cases was 271 million, and this number practically doubled in 2019 to 523 million.⁸¹ Among CVDs, ischemic heart disease and stroke are the principal causes of global mortality and a major contributor to disability. In 2019, ischemic heart disease represented 182 million DALYs and 14 million deaths around the globe.⁸²

⁷² U.S Centers for Disease Control and Prevention, 'Heart Disease Risk Factors' (CDC 2024) <<https://www.cdc.gov/heart-disease/risk-factors/index.html>> accessed 3 August 2022.

⁷³ *ibid.*

⁷⁴ *ibid.*

⁷⁵ *ibid.*

⁷⁶ *ibid.*

⁷⁷ *ibid.*

⁷⁸ *ibid.*

⁷⁹ OECD, 'Health at a Glance: Europe 2016 State of Health in the EU Cycle' (OECD Publishing 2016).

⁸⁰ Federal Statistical Office, *Maladies cardiovasculaires*, last updated 27 October 2022, <<https://www.bfs.admin.ch/bfs/fr/home/statistiques/sante/etat-sante/maladies/cardiovasculaires.html>> accessed 25 June 2025.

⁸¹ Gregory A Roth and others, 'Global Burden of Cardiovascular Diseases and Risk Factors, 1990-2019: Update from the GBD 2019 Study' (2020) 76 *Journal of the American College of Cardiology*.

⁸² *ibid.*

2.2 Diabetes

Diabetes is a metabolic disease whose main characteristic is elevated levels of blood glucose or blood sugar, and can result in cardiovascular disease, blindness, kidney failure, and loss of limbs.⁸³ Diabetes is classified as type 1 and type 2. The first type is characterized by the pancreas producing little or no insulin by itself.⁸⁴ Also, diabetes type 1 is not preventable and is most commonly developed during childhood.⁸⁵

In contrast, type 2 diabetes, which is most common in adults, is preventable and occurs when the body becomes resistant to insulin or doesn't produce enough insulin.⁸⁶ The risk of insulin resistance is higher when there is excess body weight, physical inactivity, and a high intake of saturated fatty acids.⁸⁷ Currently, more than 95% of people with diabetes have type 2 diabetes.

88

As reported by the WHO, 422 million people around the world have diabetes, and 1.5 million people die because of the disease each year.⁸⁹ The WHO declares that between 2000 and 2016, there was a 5% increase in premature mortality rates from diabetes, and in 2019, 48% of all deaths related to diabetes were premature deaths.⁹⁰

Diabetes is the leading cause of amputation, as well as dialysis and kidney transplant.⁹¹ Because of the amputation, people developed a disability and are unable to work, increasing the costs for healthcare systems. In 2019, it is estimated that on a global scale, diabetes was responsible for nearly \$760 billion in health expenditure, and this number is expected to reach USD 825 billion by 2030 and USD 845 billion by 2045.⁹² Furthermore, the International Diabetes Federation estimated that the majority of countries dedicate 5–20% of total healthcare expenditures to diabetes treatment and management.⁹³

⁸³ World Health Organization, 'Diabetes' (*WHO*) <https://www.who.int/health-topics/diabetes#tab=tab_1> accessed 23 March 2022.

⁸⁴ *Ibid.*

⁸⁵ NCD Alliance, 'Diabetes' (*NCD Alliance* 2015) <<https://ncdalliance.org/why-ncds/ncds/diabetes>> accessed 23 March 2022.

⁸⁶ WHO, 'Diabetes' (n 83).

⁸⁷ *ibid.*

⁸⁸ *ibid.*

⁸⁹ *ibid.*

⁹⁰ *ibid.*

⁹¹ U.S. Centers for Disease Control and Prevention, 'Diabetes Basics' (*CDC*) <<https://www.cdc.gov/diabetes/about/index.html>> accessed 23 July 2022.

⁹² Rhys Williams and others, 'Global and Regional Estimates and Projections of Diabetes-Related Health Expenditure: Results from the International Diabetes Federation Diabetes Atlas, 9th Edition' (2020) 162 *Diabetes Research and Clinical Practice*.

⁹³ Perianayagam Arokiasamy, Supriya Salvi and Y Selvamani, 'Global Burden of Diabetes Mellitus' in Robin Haring and others (eds), *Handbook of Global Health* (Springer 2021).

In 2017, nearly 463 million people were living with type 2 diabetes.⁹⁴ And the International Diabetes Federation estimated that the number of people, over 20 years old, living with diabetes can reach 700.2 million by 2045.⁹⁵ It is estimated that in Switzerland nearly half a million people suffer from various forms of diabetes.⁹⁶

Type 1 diabetes is treated with insulin, and type 2 diabetes is treated with oral medication to control blood sugar levels, but may also require insulin.⁹⁷ However, insulin and diabetes medication can be very expensive, and not all populations have access to them, bringing into discussion the topic of healthcare costs and inequalities in healthcare systems. For illustrative purposes, the International Diabetes Federation estimates that the costs of insulin and blood glucose monitoring in many countries can represent half of a family's average disposable income.⁹⁸ Nevertheless, it is possible to prevent type 2 diabetes by adopting a healthy lifestyle, which includes a healthy diet, low in saturated fats and sugar, the practice of physical activity, and avoidance of smoking.

2.3 Cancer

According to the WHO, cancer is a broad term for a vast group of diseases that affect any part of the body.⁹⁹ The main characteristic of the disease is the rapid creation of abnormal cells that grow very fast and beyond the usual boundaries.¹⁰⁰ There are different types of cancer, and the most common are breast, lung, colon and rectum, prostate, skin, liver, and stomach cancer.¹⁰¹ In 2018, lung cancer was the most diagnosed cancer in both sexes combined and the major cause of death.¹⁰² In Switzerland, cancer is the second leading cause of death, it is responsible for nearly a quarter of all deaths.¹⁰³

⁹⁴ Saeid Safiri and others, 'Prevalence, Deaths and Disability-Adjusted-Life-Years (Dalys) due to Type 2 Diabetes and Its Attributable Risk Factors in 204 Countries and Territories, 1990-2019: Results from the Global Burden of Disease Study 2019' (2022) 13 *Frontiers in Endocrinology*.

⁹⁵ *ibid.*

⁹⁶ Office Fédéral de la Santé Publique, *Diabète*, last modified 24 July 2024 <<https://www.bag.admin.ch/fr/diabete-fr>> accessed 20 June 2025.

⁹⁷ WHO, 'Diabetes' (n 83).

⁹⁸ Arokiasamy, Salvi and Selvamani, 'Global Burden of Diabetes Mellitus' (n 93).

⁹⁹ World Health Organization, 'Cancer' (*WHO*) <<https://www.who.int/news-room/fact-sheets/detail/cancer>> accessed 30 March 2022.

¹⁰⁰ *ibid.*

¹⁰¹ *ibid.*

¹⁰² Twalib A Ngoma and Mamsau Ngoma, 'Global Burden of Cancer' in Robin Haring and others (eds), *Handbook of Global Health* (Springer 2021).

¹⁰³ Office Fédéral de la Santé Publique, *Cancer*, last modified 21 May 2024 <<https://www.bag.admin.ch/fr/cancer>> accessed 20 June 2025.

In 2020, cancer killed approximately 10 million people around the world.¹⁰⁴ Cancer is caused by a combination of genetic factors and external factors related to behavior. Some specific external agents are known for causing cancer: physical carcinogens (ultraviolet and ionizing radiation), chemical carcinogens (asbestos, components of tobacco smoke, alcohol), and biological carcinogens, such as infections from certain viruses, bacteria, or parasites.¹⁰⁵

Air pollution, alcohol consumption, unhealthy diet, physical inactivity, and tobacco use are classified as risk factors for cancer.¹⁰⁶ Also, some infections can increase the risk of developing cancer, like the human papillomavirus, hepatitis B, and hepatitis C virus.¹⁰⁷

In 2015, 20% of cancer deaths around the world were due to tobacco use.¹⁰⁸ Likewise, it is estimated that globally about 15%–20 % of cancers are linked to excess body weight, physical inactivity, and/or poor nutrition.¹⁰⁹ Hence, in accordance with the WHO, between 30% and 50% of cancer deaths could be prevented through strategies to avoid the risk factors such as not smoking tobacco, having a healthy diet, practice of physical activity, limiting the consumption of alcohol, avoiding ultraviolet radiation exposure, getting vaccinated against human papillomavirus and hepatitis B.¹¹⁰

A lot of progress has been made in the treatment of cancer in the past few years. However, the financial costs are high. Direct financial costs of cancer include the costs of care and rehabilitation for the treatment of the disease.¹¹¹ Moreover, indirect costs include the loss of economic output due to missed work (morbidity costs) and premature death (mortality costs).¹¹² Hence, the measures for the prevention of cancer are highly relevant. The global cost of cancer is estimated to be hundreds of billions of dollars per year.¹¹³ In Europe, the estimated annual healthcare expenditure for cancer was €83 billion in 2014.¹¹⁴ In 2012, in developing countries such as Brazil, Russia, Indonesia, China, and South Africa, the total cost of lost productivity because of premature mortality from cancer was estimated to be \$46.3 billion.¹¹⁵

¹⁰⁴ WHO, 'Cancer' (n 99).

¹⁰⁵ *ibid.*

¹⁰⁶ *ibid.*

¹⁰⁷ NCD Alliance, 'Cancer' (*NCD Alliance* 2015) <<https://ncdalliance.org/why-ncds/ncds/cancer>> accessed 31 March 2022.

¹⁰⁸ Ngoma and Ngoma, 'Global Burden of Cancer' (n 102).

¹⁰⁹ *ibid.*

¹¹⁰ WHO, 'Cancer' (n 99).

¹¹¹ Ngoma and Ngoma, 'Global Burden of Cancer' (n 102).

¹¹² *ibid.*

¹¹³ *ibid.*

¹¹⁴ *ibid.*

¹¹⁵ *ibid.*

2.4 Chronic respiratory diseases

Chronic respiratory diseases (CRDs) impact the airways and other structures of the lungs. The most common CRDs are chronic obstructive pulmonary disease, asthma, occupational lung diseases, and pulmonary hypertension. The use of tobacco, air pollution, and occupational chemicals are considered the main risk factors for CRDs.¹¹⁶

According to a study by the Global Burden of Disease, in 2017, approximately 545 million people were living with a chronic respiratory condition, which accounts for 7.4% of the world's population.¹¹⁷ Furthermore, it is estimated that in the same year, 3.9 million people died due to CRDs, and they accounted for 1470 disability-adjusted life-years (DALYs) per 100,000 individuals.¹¹⁸ In addition, the leading risk factor for chronic respiratory diseases globally was smoking.¹¹⁹ Moreover, in 2019, in 28 EU member states, it is estimated that €380 billion was spent on the care of patients with chronic respiratory diseases (including costs of direct primary and inpatient health care, costs of lost productivity, and the monetized value of DALYs).¹²⁰

Chronic obstructive pulmonary disease is one of the most common chronic respiratory diseases and is the third major cause of death worldwide.¹²¹ In 2019, 3.23 million global deaths were caused by chronic obstructive pulmonary disease.¹²² In addition, almost 90% of the deaths occurred in people under 70 years of age in low- and middle-income countries (LMIC).¹²³ Chronic obstructive pulmonary disease causes airflow blockage and breathing-related problems. The disease is preventable and known as “emphysema” or “chronic bronchitis”. One of the principal risk factors for developing chronic obstructive pulmonary disease is tobacco exposure through smoking and secondhand smoke.¹²⁴

¹¹⁶ World Health Organization, ‘Chronic Respiratory Diseases’ (*WHO* 2019) <https://www.who.int/health-topics/chronic-respiratory-diseases#tab=tab_1> accessed 31 March 2022.

¹¹⁷ Joan B Soriano and others, ‘Prevalence and Attributable Health Burden of Chronic Respiratory Diseases, 1990–2017: A Systematic Analysis for the Global Burden of Disease Study 2017’ (2020) 8 *The Lancet Respiratory Medicine* 585.

¹¹⁸ *ibid.*

¹¹⁹ *ibid.*

¹²⁰ *ibid.*

¹²¹ World Health Organization, ‘Chronic Obstructive Pulmonary Disease (COPD)’ (*WHO*) <[https://www.who.int/news-room/fact-sheets/detail/chronic-obstructive-pulmonary-disease-\(copd\)](https://www.who.int/news-room/fact-sheets/detail/chronic-obstructive-pulmonary-disease-(copd))> accessed 26 April 2022.

¹²² *ibid.*

¹²³ *ibid.*

¹²⁴ U.S Centers for Disease Control and Prevention, ‘Smoking and Tobacco Use’ (*CDC* 2020) <https://www.cdc.gov/tobacco/basic_information/health_effects/index.htm> accessed 26 April 2022.

3 Obesity: a growing NCD-related aspect

To conclude, it is crucial to mention obesity when discussing non-communicable diseases.¹²⁵ Obesity and overweight are defined as abnormal or excessive fat accumulation that presents a health risk.¹²⁶ Obesity and overweight are commonly defined by the body mass index (BMI), a simple weight-for-height index. In adults, a BMI above or equal to 25 is considered overweight, while a BMI equal to or higher than 30 is considered obesity.¹²⁷ Obesity is very likely to lead to other NCDs, for instance, cardiovascular (stroke and heart attacks), type 2 diabetes, and some types of cancer.¹²⁸

According to the WHO, on a global scale, obesity has practically tripled since 1975, and more than 4 million people die each year due to diseases related to obesity or being overweight.¹²⁹ Furthermore, it is estimated that the European Countries will spend nearly 8.4% of their health budget to provide treatment for overweight-related diseases.¹³⁰ The OECD projects that overweight will be responsible for 70% of all treatment costs for diabetes, 23% of treatment costs for cardiovascular diseases, and 9% for cancers.¹³¹

In Switzerland, 43% of the adult population is overweight or obese, and 12% are affected by obesity, while among children and adolescents, 15% are overweight or obese and 3% live with obesity.¹³² According to the Swiss Federal Office of Public Health, the annual costs related to overweight, obesity, and associated diseases nearly tripled between 2002 and 2012, rising from 2.65 billion francs to almost 8 billion francs, including direct healthcare costs and indirect costs such as productivity losses.¹³³

In 2013, the American Medical Association recognized obesity as a disease. However, this is a controversial topic.¹³⁴ This thesis will not explore this discussion further. Obesity is related to

¹²⁵ Gostin, *Global Health Law* (n 3).

¹²⁶ World Health Organization, 'Obesity' (WHO) <https://www.who.int/health-topics/obesity#tab=tab_1> accessed 16 May 2022.

¹²⁷ World Health Organization, 'Obesity and Overweight' (WHO) <<https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight>> accessed 30 July 2022.

¹²⁸ World Health Organization, 'WHO European Regional Obesity Report 2022' (WHO) <<https://www.who.int/europe/publications/i/item/9789289057738>> accessed 30 July 2022.

¹²⁹ WHO, 'Obesity' (n 126).

¹³⁰ OECD, *The Heavy Burden of Obesity: The Economics of Prevention* (OECD Health Policy Studies 2019).

¹³¹ *ibid.*

¹³² Office Fédéral de la Santé Publique, *Surpoids et obésité*, 6 mars 2024 <<https://www.bag.admin.ch/fr/surpoids-et-obesite>> accessed 20 June 2025.

¹³³ Office Fédéral de la Santé Publique, *Coûts occasionnés par l'obésité en Suisse*, 7 janvier 2022 <<https://www.bag.admin.ch/fr/couts-occasionnes-par-lobesite-en-suisse>> accessed 20 June 2025.

¹³⁴ Howard Rosen, 'Is Obesity a Disease or a Behavior Abnormality? Did the AMA Get It Right?' (2014) 111 *Missouri Medicine* 104.

unhealthy diets, is directly associated with other non-communicable diseases, and is associated with the activity of the food and sweetened beverage industry. Therefore, it is imperative to mention it to enrich the discussion of the changes in the lifestyle as a response to tackling NCDs.

Finally, obesity and non-communicable diseases are closely tied to human behavior. However, it is essential to emphasize that human behavior is deeply embedded within, and conditioned by, the socio-economic and environmental contexts that shape our lives.¹³⁵ It must not be mistaken for, or reduced to, mere individual choice or exclusive personal responsibility. Contemporary lifestyles are significantly influenced by corporate actions and systemic forces, which shape the environments in which individuals make choices.¹³⁶ To avoid misunderstandings, it is crucial to distinguish between individual decision-making and the broader collective and environmental factors at play.

4 Key risk factors for NCDs

4.1 Tobacco

Public health burden of tobacco as the starting point of NCD prevention regulation

Tobacco is the only risk factor for NCDs subject to a binding international instrument¹³⁷ Through this research, many analogies will be made to the tobacco legal measures and the tobacco industry strategies, since it has many similarities with the food industry. Therefore, it is important to explain tobacco as one of the key risk factors for NCDs.

Tobacco is a huge concern for public health. Currently, more than 7 million people die from direct smoking, and around 1.2 million people die from being exposed to second-hand smoke.¹³⁸ It is estimated that in the past 30 years, smoking tobacco was responsible for more than 200

¹³⁵ Part 1, Chapter 1, II, NCD risk distribution and social determinants of health.

¹³⁶ Part 1, Chapter 2, II, 3 Commercial determinants of health.

¹³⁷ Part 2, Chapter 5.

¹³⁸ World Health Organization, 'Tobacco' (*WHO*) <<https://www.who.int/news-room/fact-sheets/detail/tobacco>> accessed 19 May 2022.

million deaths in the world.¹³⁹ Moreover, in 2019, smoking tobacco represented 200 million DALYs and was the major risk factor for death among men.¹⁴⁰

In Switzerland, tobacco use causes approximately 9,500 deaths each year, accounting for 14% of all deaths.¹⁴¹ Most tobacco-related deaths result from cardiovascular diseases (34%), lung cancer (29%), respiratory diseases (17%), or other cancers (16%).¹⁴²

In 2017, smoking tobacco was the fifth leading cause of stroke worldwide.¹⁴³ Likewise, second-hand smoking increases the risk of death from CVDs.¹⁴⁴ In addition, tobacco represents a massive economic loss globally. The total tobacco-related disease burden is estimated to be US\$1.4 trillion, which is equivalent to 1.8% of annual global GDP.¹⁴⁵

In 1964, the first report of the Surgeon General’s Advisory Committee on Smoking and Health was published in the United States. Led by Surgeon General Luther L. Terry, the report is considered a landmark because it linked smoking cigarettes with dangerous health effects, including lung cancer and heart disease.¹⁴⁶

In 1999, the United States filed a lawsuit against Philip Morris on the basis that the cigarette manufacturers fraudulently misled American consumers for decades about the risks and dangers of cigarette smoking and exposure to secondhand smoke.¹⁴⁷ In 2006, US District Judge Gladys Kessler issued her verdict recognizing that cigarette companies were guilty of concealing scientific evidence about nicotine being addictive, misleading people about the harms of smoking by using terms such as “low tar,” “light,” “ultra-light,” and denying the effects of second-hand smoking. The decision was upheld by the US Court of Appeals in 2009.¹⁴⁸

¹³⁹ Marissa B Reitsma and others, ‘Spatial, Temporal, and Demographic Patterns in Prevalence of Smoking Tobacco Use and Attributable Disease Burden in 204 Countries and Territories, 1990–2019: A Systematic Analysis from the Global Burden of Disease Study 2019’ (2021) 397 *The Lancet* 2337.

¹⁴⁰ *ibid.*

¹⁴¹ Federal Office of Public Health, *Chiffres et faits sur le tabac*, last updated 16 February 2024, <<https://www.bag.admin.ch/bag/fr/home/zahlen-und-statistiken/zahlen-fakten-zu-sucht/zahlen-fakten-zu-tabak.html>> accessed 20 June 2025

¹⁴² *ibid.*

¹⁴³ Reddy and Mathur, ‘Global Burden of CVD’ (n 8).

¹⁴⁴ *ibid.*

¹⁴⁵ Douglas Bettcher and others, ‘Tobacco as Global Health Risk Factor’ in Robin Haring and others (eds), *Handbook of Global Health* (Springer 2021).

¹⁴⁶ U.S Centers for Disease Control and Prevention, ‘History of the Surgeon General’s Report on Smoking and Health’ (CDC) <https://www.cdc.gov/tobacco/data_statistics/sgr/history/index.htm> accessed 12 May 2022.

¹⁴⁷ Nicholas Freudenberg, ‘Lethal but Legal: Corporations, Consumption, and Protecting Public Health’ (CUNY Graduate School of Public Health & Health Policy 2014).

¹⁴⁸ *ibid.*

Tobacco products

Tobacco is defined as a plant with leaves that have high levels of nicotine, which is an addictive chemical.¹⁴⁹ Tobacco is harmful in all forms and is a key factor in the development of cardiovascular disease, cancer, chronic respiratory disease, and other diseases, including tuberculosis and neurological disorders.¹⁵⁰

The most common form of tobacco in the world is cigarette smoking. Waterpipe tobacco, smokeless tobacco products, cigars, cigarillos, roll-your-own tobacco, pipe tobacco, bidis, and kreteks are other examples of tobacco products.¹⁵¹ Tobacco is the only legal consumer product that kills up to half of its users.¹⁵²

It must be pointed out that not only direct smokers are affected by the dangers of tobacco. It is proven that secondhand smoke can cause cancer.¹⁵³ Secondhand tobacco smoke, also known as environmental tobacco smoke or passive smoke, is the combination of the smoke from the burning end of a tobacco product and the smoke exhaled by a smoker.¹⁵⁴ Secondhand tobacco smoke has more than 7,000 chemicals, and at least 69 of them are recognized to cause cancer, such as arsenic, benzene, beryllium, chromium, and formaldehyde.¹⁵⁵ Furthermore, children are highly affected by secondhand smoke, and 65,000 die per year as a result of illness due to breathing the smoke.¹⁵⁶

¹⁴⁹ National Cancer Institute, 'NCI Dictionary of Cancer Terms' (*National Cancer Institute* 2011) <<https://www.cancer.gov/publications/dictionaries/cancer-terms/def/tobacco>> accessed 28 April 2022.

¹⁵⁰ NCD Alliance, 'Tobacco Use' (*NCD Alliance* 2015) <<https://ncdalliance.org/why-ncds/risk-factors-prevention/tobacco-use>> accessed 28 April 2022.

¹⁵¹ WHO, 'Tobacco' (n 138).

¹⁵² *ibid.*

¹⁵³ U.S Centers for Disease Control and Prevention, 'Centers for Disease Control and Prevention, Office on Smoking and Health Summary of Scientific Evidence: Secondhand Smoke Exposure and the Impact of Smokefree Policies' (*CDC* 2021) <https://www.cdc.gov/tobacco/data_statistics/evidence/pdfs/secondhand-smoke-smokefree-policies-508.pdf> accessed 28 April 2022.

¹⁵⁴ National Cancer Institute, 'Secondhand Tobacco Smoke (Environmental Tobacco Smoke)' (*National Cancer Institute* 2016) <<https://www.cancer.gov/about-cancer/causes-prevention/risk/substances/secondhand-smoke>> accessed 28 April 2022.

¹⁵⁵ *ibid.*

¹⁵⁶ World Health Organization, 'New Brief Outlines Devastating Harms from Tobacco Use and Exposure to Second-Hand Tobacco Smoke during Pregnancy and throughout Childhood - Report Calls for Protective Policies' (*WHO* 2021) <<https://www.who.int/news/item/16-03-2021-new-brief-outlines-devastating-harms-from-tobacco-use-and-exposure-to-second-hand-tobacco-smoke-during-pregnancy-and-throughout-childhood>> accessed 28 April 2022.

New tobacco products and e-cigarettes

Recently, new forms of tobacco consumption have emerged as significant public health concerns. Among these are heated tobacco products marketed as alternatives to traditional cigarettes.¹⁵⁷ For instance, iQOS from Philip Morris International, contain nicotine, a highly addictive substance, along with various non-tobacco additives.¹⁵⁸

Additionally, electronic nicotine delivery systems and electronic non-nicotine delivery systems have gained widespread popularity, especially among children and young people, with e-cigarettes being the most common form. Other devices include e-cigars and e-pipes.¹⁵⁹ Electronic nicotine delivery systems products contain varying amounts of nicotine and release harmful emissions during use. The act of using these products is commonly referred to as “vaping”.¹⁶⁰

Another concerning product is nicotine pouches, pre-portioned, smokeless pouches that contain nicotine. While similar in appearance and usage to traditional smokeless tobacco products like snus (placed between the gum and lip), nicotine pouches are often marketed as “tobacco-free.”

161

4.2 Harmful use of alcohol

Alcohol is considered a toxic and psychoactive substance with properties that cause dependence.¹⁶² Alcohol is the most consumed psychoactive substance worldwide.¹⁶³ The harmful use of alcohol can result in mental and behavioral disorders, for instance, alcohol dependence.¹⁶⁴ Also, excessive consumption is linked to non-communicable diseases, including cirrhosis of the liver, pancreatitis, cancers (oral and pharynx, larynx, esophagus, liver,

¹⁵⁷ World Health Organization, ‘Heated Tobacco Products: Information Sheet - 2nd Edition’ (*WHO*) <<https://www.who.int/publications/i/item/WHO-HEP-HPR-2020.2>> accessed 2 April 2025.

¹⁵⁸ *ibid.*

¹⁵⁹ World Health Organization, ‘Electronic Cigarettes (E-Cigarettes)’ (*WHO* 2024) <<https://www.who.int/publications/i/item/WPR-2024-DHP-001>> accessed 2 April 2025.

¹⁶⁰ World Health Organization, ‘Tobacco: E-Cigarettes’ (*WHO* 2024) <<https://www.who.int/news-room/questions-and-answers/item/tobacco-e-cigarettes>> accessed 2 April 2025.

¹⁶¹ WHO, ‘Tobacco’ (n 138).

¹⁶² World Health Organization, ‘Harmful Use of Alcohol’ (*WHO* 2018) <https://www.who.int/health-topics/alcohol#tab=tab_1> accessed 20 May 2022.

¹⁶³ Jürgen Rehm, Jakob Manthey and Kevin D. Shield, ‘Global Health Risk Factors: Alcohol Consumption’ in Robin Haring and others (eds), *Handbook of Global Health* (Springer 2021).

¹⁶⁴ World Health Organization, ‘Alcohol’ (*WHO*) <<https://www.who.int/news-room/fact-sheets/detail/alcohol>> accessed 12 August 2022.

colorectal, female breast), ischaemic heart disease, dilated cardiomyopathy, cardiac dysrhythmias, and hemorrhagic strokes.¹⁶⁵

In 1988, the International Agency for Research on Cancer of the World Health Organization classified alcoholic beverages as carcinogenic.¹⁶⁶ According to the WHO, 5.3% of all deaths across the world are due to the harmful use of alcohol.¹⁶⁷ In addition, in 2016, alcohol represented 132 million DALYs.¹⁶⁸ In the European Union, alcohol was the third leading risk factor for disease and mortality, behind only from tobacco and high blood pressure.¹⁶⁹

In Switzerland, harmful alcohol consumption results in approximately 2.8 billion francs in annual costs, including 477 million francs in direct healthcare expenses related to alcohol-attributable diseases. Among alcohol-related deaths, 36% are due to cancers and 21% to diseases of the digestive system¹⁷⁰

The World Health Organization's International Classification of Diseases and Related Health Problems (ICD), specifically the ICD-10 Classification of Mental and Behavioral Disorders, defines "harmful use" as: "*a pattern of psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected psychoactive substances) or mental (e.g., episodes of depressive disorder secondary to heavy consumption of alcohol).*"¹⁷¹

The WHO defines the harmful use of alcohol as "*the proportion of adults (15+ years) who have had at least 60 grams or more of pure alcohol on at least one occasion in the past 30 days*".¹⁷² Moreover, according to the Sustainable Development Goals (SDG) indicator 3.5.2, the concept of harmful use of alcohol is defined "*according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in liters of pure alcohol.*"¹⁷³

¹⁶⁵ NCD Alliance, 'Alcohol Use' (NCD Alliance) <<https://ncdalliance.org/why-ncds/risk-factors-prevention/harmful-use-of-alcohol>> accessed 22 May 2022.

¹⁶⁶ Gianni Testino, 'The Burden of Cancer Attributable to Alcohol Consumption' (2011) 6 *Mædica* 313.

¹⁶⁷ WHO, 'Alcohol' (n 164).

¹⁶⁸ Seung Ha Park and Dong Joon Kim, 'Global and Regional Impacts of Alcohol Use on Public Health: Emphasis on Alcohol Policies' (2020) 26 *Clinical and Molecular Hepatology* 652.

¹⁶⁹ OECD European Union, *State of Health in the EU Cycle: Health at a Glance: Europe 2016* (OECD Publishing).

¹⁷⁰ Federal Office of Public Health, *Chiffres et faits sur l'alcool*, last updated 16 February 2024, <<https://www.bag.admin.ch/fr/consommation-dalcool-en-suisse-faits-et-chiffres>> accessed 20 June 2025.

¹⁷¹ World Health Organization, *ICD-10: International Statistical Classification of Diseases and Related Health Problems, 10th Revision*, 'F10–F19 Mental and behavioural disorders due to psychoactive substance use' (WHO 2016) <<https://icd.who.int/browse10/2016/en#/F10-F19>> accessed 9 July 2025.

¹⁷² Jürgen Rehm and others, 'What Is the Best Indicator of the Harmful Use of Alcohol? A Narrative Review' (2020) 39 *Drug and Alcohol Review* 624.

¹⁷³ United Nations, 'SDG Indicators' (*United Nations Sustainable Development*) <<https://unstats.un.org/sdgs/metadata?Text=&Goal=3&Target=3.4>> accessed 20 May 2022.

Thus, an important indicator of the harmful use of alcohol is the alcohol per capita consumption (APC).

The definition of alcohol per capita consumption is: “total (sum of three-year average recorded APC and unrecorded APC adjusted for tourist consumption) amount of pure alcohol consumed per adult (15+ years), in a calendar year, in liters of pure alcohol”.¹⁷⁴ Along these lines, the term recorded alcohol alludes to the official statistics in the country, such as production, import, export, and sales or taxation data.¹⁷⁵ The alcohol, which is not taxed and is outside the usual system of governmental control, for instance, home-produced alcohol and smuggled alcohol, is described as unrecorded alcohol consumption.¹⁷⁶ Finally, tourist consumption represents the foreign tourists visiting the country and the inhabitants visiting other countries.¹⁷⁷

4.3 Unhealthy diet

Overview

An unhealthy diet is related to diseases such as type 2 diabetes, cardiovascular diseases, for instance, stroke, and some cancers.¹⁷⁸ According to the WHO, a healthy diet for adults would include fruits, vegetables, legumes, nuts, and whole grains.¹⁷⁹ A healthy diet is low in sugar, salt, trans-fats, and saturated fats.

According to the Global Burden of Diseases, Injuries, and Risk Factors Study, in 2017, the consumption of unhealthy products such as sugary beverages, sodium, and processed and red meat was above the recommended level throughout the world.¹⁸⁰ Moreover, the study showed that in the same year, on a global scale, dietary factors were responsible for 11 million deaths and 255 million DALYs in adults.¹⁸¹ In addition, only three factors were responsible for more

¹⁷⁴ United Nations, ‘SDG Indicators. Indicator 3.5.2: Alcohol per Capita Consumption’ (*United Nations Sustainable Development*) <<https://unstats.un.org/sdgs/metadata/files/Metadata-03-05-02.pdf>> accessed 7 July 2022.

¹⁷⁵ *ibid.*

¹⁷⁶ *ibid.*

¹⁷⁷ *ibid.*

¹⁷⁸ NCD Alliance, ‘Unhealthy Diets and Malnutrition’ (*NCD Alliance* 2015) <<https://ncdalliance.org/why-ncds/risk-factors-prevention/unhealthy-diets-and-malnutrition>> accessed 20 May 2022.

¹⁷⁹ World Health Organization, ‘Healthy Diet’ (*WHO* 2020) <<https://www.who.int/news-room/fact-sheets/detail/healthy-diet>> accessed 20 May 2022.

¹⁸⁰ Nita G Forouhi and Nigel Unwin, ‘Global Diet and Health: Old Questions, Fresh Evidence, and New Horizons’ (2019) 393 *The Lancet* 1916.

¹⁸¹ *ibid.*

than half of the diet-related deaths: high intake of sodium, low intake of whole grains, and low intake of fruit.¹⁸²

The Industrial Revolution and the Modern Age have impacted the lifestyle of human beings and their diets.¹⁸³ This period marks the emergence of the “Western Diet,” also known as the “Standard American Diet,” which is composed of fast food, processed food, and pre-packaged food.¹⁸⁴ These foods are high in sugar, trans fat, saturated fat, and sodium.¹⁸⁵ This diet that started in the United States has reached many countries, especially developing ones. Another relevant factor to this nutrition transition is the process of urbanization. It has been established that urban diets tend to include foods higher in fat and sugar, food prepared away from the home, and processed foods.¹⁸⁶

Fats

Saturated fats are primarily found in animal products such as meat, milk, butter, and some plant food products, such as coconut oil.¹⁸⁷ Trans-fats, also called trans-fatty acids, are mostly found in industrially-produced products such as fried food, and pre-packaged snacks and foods, for instance, frozen pizza, pies, cookies, cooking oils, and spreads.¹⁸⁸ The production of trans fat is an industrial process that adds hydrogen to vegetable oil, which results in the oil becoming solid at room temperature.¹⁸⁹

Trans fat products are considered the most harmful to the heart and blood vessels since they raise bad LDL and lower the good HDL, increasing the risk of heart attack or stroke.¹⁹⁰

¹⁸² *ibid.*

¹⁸³ Pedro Carrera-Bastos and others, ‘The Western Diet and Lifestyle and Diseases of Civilization’ (2011) 2 *Research Reports in Clinical Cardiology* 15.

¹⁸⁴ David Grotto and Elisa Zied, ‘The Standard American Diet and Its Relationship to the Health Status of Americans’ (2010) 25 *Nutrition in Clinical Practice* 603.

¹⁸⁵ Varundeep Rakhra and others, ‘Obesity and the Western Diet: How We Got Here’ (2020) 117 *Missouri Medicine* 536.

¹⁸⁶ Michele A Mendez and Barry M Popkin, ‘Globalization, Urbanization and Nutritional Change in the Developing World’ (2004) 1 *Electronic Journal of Agricultural and Development Economics* 220.

¹⁸⁷ Harvard School of Public Health, ‘Types of Fat’ (*The Nutrition Source* 2018) <<https://www.hsph.harvard.edu/nutritionsource/what-should-you-eat/fats-and-cholesterol/types-of-fat/>> accessed 22 May 2022.

¹⁸⁸ WHO, ‘Healthy Diet’ (n 179).

¹⁸⁹ Mayo Clinic, ‘Trans Fat: Double Trouble for Your Heart’ (*Mayo Clinic*) <<https://www.mayoclinic.org/diseases-conditions/high-blood-cholesterol/in-depth/trans-fat/art-20046114>> accessed 22 May 2022.

¹⁹⁰ *ibid.*

Moreover, they contribute to insulin resistance, increasing the chances of developing type 2 diabetes.¹⁹¹

Therefore, in order to prevent non-communicable diseases, saturated fat and trans-fat are a concern for the WHO. The WHO recommends reducing saturated fats to less than 10% of total energy intake and reducing trans fats to less than 1% of total energy intake.¹⁹² Finally, according to the WHO, a healthy diet would replace saturated and trans fats with unsaturated fats, which can be found in olive, peanut, and canola oils, avocado, nuts, and seeds. In particular, polyunsaturated fats are found in sunflower, corn oils, walnuts, flax seeds, and fish.¹⁹³

Sugar

Another major determinant of an unhealthy diet is sugar consumption. Sugar is a group of carbohydrates composed of glucose, galactose, dextrose, fructose, lactose, sucrose, etc.¹⁹⁴ Sugar can be found naturally in some foods, for instance, fruits, honey (fructose), and milk (lactose), or it can be added to food and beverages.¹⁹⁵ The most common sugar consumed is sucrose, which is also known as table sugar. This type of sugar is a disaccharide that is broken down in the body into fructose and glucose to be used for energy.¹⁹⁶

The WHO classifies free sugars as the monosaccharides and disaccharides added to foods and beverages by the manufacturer, cook, or consumer, and the sugars naturally present in honey, syrups, fruit juices, and fruit juice concentrates.¹⁹⁷ Free sugars result in excess energy intake, which contributes to obesity and overweight.¹⁹⁸ For this reason, in 1989, the WHO established a dietary goal for free sugars intake of less than 10% of total energy intake.¹⁹⁹ In 2015, the WHO suggested that the intake should be below 5% or roughly 25 grams (6 teaspoons).²⁰⁰ For

¹⁹¹ *ibid.*

¹⁹² WHO, 'Healthy Diet' (n 179).

¹⁹³ *ibid.*

¹⁹⁴ Gary Taubes, *Case against Sugar* (Knopf 2016) 24.

¹⁹⁵ *ibid.*, 25.

¹⁹⁶ *ibid.*

¹⁹⁷ World Health Organization, *Guideline: Sugars Intake for Adults and Children* (2015) <<https://www.who.int/publications-detail-redirect/9789241549028>> accessed 1 June 2022.

¹⁹⁸ *ibid.*

¹⁹⁹ *ibid.*

²⁰⁰ World Health Organization, 'WHO calls on countries to reduce sugars intake among adults and children' (*WHO* 2015) <<https://www.who.int/news/item/04-03-2015-who-calls-on-countries-to-reduce-sugars-intake-among-adults-and-children#:~:text=A%20new%20WHO%20guideline%20recommends,would%20provide%20additional%20health%20benefits>> accessed 1 June 2022.

all purposes, the intake of less than 10% is considered a strong recommendation, while the intake of less than 5% is called a conditional recommendation.²⁰¹

Sugar-sweetened beverages (SSBs) are the main source of added sugar in diets in high-income and low-income countries.²⁰² A typical 12 fl oz (355 ml) serving of soda contains 35.0–37.5 g of sugar and 140–150 calories.²⁰³ The most accepted definition of SSBs is a beverage that contains caloric sweeteners such as sucrose and high-fructose corn syrup.²⁰⁴ By now, many studies have linked the consumption of sugar-sweetened beverages to type 2 diabetes and the rise of overweight and obesity rates.²⁰⁵

Moreover, studies have shown that sugar can be addictive and that it has an effect on brain serotonin.²⁰⁶ Scientists concluded that in animals, sugar can cause dependence and that the reward for sugar can surpass cocaine.²⁰⁷ Regarding the dependence effect on human beings, there is no universal conclusion. However, due to the changes in the brain, sugar meets many of the criteria for a substance of abuse and could be potentially addictive in humans.²⁰⁸ Sugar stimulates the release of dopamine, which is also the effect caused by cocaine.²⁰⁹ Sugar can be addictive. Therefore, there is a parallel with tobacco. If we consider the addictive potential of sugar, how different would it be from the harms caused by tobacco? In addition, should we approach sugar consumption through the same lens as tobacco control?

Sodium

Likewise, sodium consumption is a concern regarding unhealthy diets. The principal source of sodium in the diet is salt.²¹⁰ The consumption of salt is directly related to hypertension, which is considered a major risk for cardiovascular disease, in particular heart attack and stroke.²¹¹

²⁰¹ WHO, *Guideline: Sugars Intake for Adults and Children* (n 197).

²⁰² Vasanti S Malik and Frank B Hu, 'The Role of Sugar-Sweetened Beverages in the Global Epidemics of Obesity and Chronic Diseases' (2022) 18 *Nature Reviews Endocrinology* 205.

²⁰³ *ibid.*

²⁰⁴ *ibid.*

²⁰⁵ *ibid.*

²⁰⁶ James J DiNicolantonio, James H O'Keefe and William L Wilson, 'Sugar Addiction: Is It Real? A Narrative Review' (2017) 52 *British Journal of Sports Medicine* 910.

²⁰⁷ *ibid.*

²⁰⁸ *ibid.*

²⁰⁹ Taubes, *Case against Sugar* (n 194) 41.

²¹⁰ World Health Organization, 'Salt Reduction' (*WHO*) <<https://www.who.int/news-room/fact-sheets/detail/salt-reduction>> accessed 3 June 2022.

²¹¹ World Health Organization, *Guideline: Sodium Intake for Adults and Children* (2012) <<https://www.who.int/publications/i/item/9789241504836>> accessed 1 June 2022.

The WHO recommendation on sodium consumption for adults is 2 g sodium/day (equivalent to 5 g salt/day).²¹² Nevertheless, according to the WHO, people consume on average 9–12 grams of salt per day, or around twice the recommended maximum level of intake.²¹³

Sodium can be found in significant amounts in processed foods such as bread, crackers, processed meats, and snack foods.²¹⁴ Thus, packaged, processed, store-bought, and restaurant foods are considered the major source of sodium in the population's diets nowadays.

UPFs

Within unhealthy diets, the consumption of ultra-processed food has been pointed out as one of the main current concerns. Ultra-processed food is ready-to-consume, and the main characteristic is that it is made from industrial ingredients and additives to make it hyper-palatable and have a “long shelf life”.²¹⁵ These products include burgers, frozen pasta, pizza and pasta dishes, nuggets and sticks, crisps, biscuits, confectionery, cereal bars, carbonated and other sugary drinks, and various snack products.²¹⁶ They are energy-dense, low in dietary fiber, and high in unhealthy types of dietary fat, free sugars, and sodium.²¹⁷

The link between ultra-processed food and NCDs is attracting growing attention in the public health scenario.²¹⁸ There is a lot of discussion around the term ultra-processed with the most accepted definition being the NOVA classification which considers ultra-processed food industrial formulations made entirely or mostly from substances extracted from foods (oils, fats, sugar, starch, and proteins), derived from food constituents (hydrogenated fats and modified starch), or synthesized in laboratories from food substrates or other organic sources (flavor enhancers, colors, and several food additives used to make the product hyper-palatable). Manufacturing techniques include extrusion, moulding, and preprocessing by frying.²¹⁹ According to the widely used NOVA classification system, ultra-processed foods are industrial

²¹² *ibid.*

²¹³ *ibid.*

²¹⁴ *ibid.*

²¹⁵ Carlos A Monteiro and others, ‘Ultra-Processed Products Are Becoming Dominant in the Global Food System’ (2013) 14 *Obesity Reviews* 21; Barry M Popkin and Shu Wen Ng, ‘The Nutrition Transition to a Stage of High Obesity and Noncommunicable Disease Prevalence Dominated by Ultra-Processed Foods Is Not Inevitable’ (2021) 23 *Obesity Reviews*.

²¹⁶ *ibid.*

²¹⁷ *ibid.*

²¹⁸ Robert H Lustig, ‘Ultraprocessed Food: Addictive, Toxic, and Ready for Regulation’ (2020) 12 *Nutrients* 3401.

²¹⁹ Carlos A Monteiro and others, ‘Ultra-Processed Foods: What They Are and How to Identify Them’ (2019) 22 *Public Health Nutrition* 936.

formulations typically composed of five or more ingredients, including substances not commonly used in home cooking.²²⁰ Their affordability, high palatability, aggressive marketing, and long shelf life make them particularly attractive to consumers.²²¹

It has been highlighted that UPFs are engineered to be overconsumed.²²² Finally, in a recent joint statement, Food and Agriculture Organization (FAO) and WHO stated that “*large and growing body of evidence suggests that consumption of highly processed foods described as “ultra-processed” foods (UPF) by the NOVA classification scheme (NOVA classification group 4) is associated with negative health outcomes. These include risk of premature mortality, cancer, cardiovascular diseases, overweight, obesity and type 2 diabetes, as well as impaired mental, respiratory and gastrointestinal health*”.²²³

Malnutrition and food insecurity

Finally, it is essential to establish the relationship between an unhealthy diet and malnutrition. Malnutrition is characterized by deficiencies, excesses, or imbalances in the intake of energy/nutrients.²²⁴ Malnutrition can take different formats: undernutrition, which is when there is a lack of food ingestion and can be wasting (low weight-for-height), stunting (low height-for-age), and underweight (low weight-for-age); micronutrient-related malnutrition, which happens when there is a micronutrient deficiency or micronutrient excess.²²⁵ And lastly, overweight and obesity result from an imbalance between a high amount of energy consumed and little energy expended.²²⁶ Overweight, obesity, and diet-related noncommunicable diseases are the relevant forms of malnutrition to this research.

In this line, it is imperative to highlight that nowadays food insecurity is not only about not having enough food, but also includes the fact that there is the availability of too much unhealthy food. Studies call attention to the fact that ultra-processed food and “fast food,” which

²²⁰ Samuel J Dicken and Rachel L Batterham, ‘Ultra-Processed Food: A Global Problem Requiring a Global Solution’ (2022) 10 *The Lancet Diabetes & Endocrinology*.

²²¹ Carlos A Monteiro and others, ‘Ultra-Processed Foods, Diet Quality, and Health Using the NOVA Classification System Prepared By’ (FAO 2019).

²²² Kevin D Hall, ‘Ultra-Processed Diets Cause Excess Calorie Intake and Weight Gain: An Inpatient Randomized Controlled Trial of Ad Libitum Food Intake’ (2019) 30 *Cell Metabolism*.

²²³ Food and Agriculture Organization of the United Nations and World Health Organization, *What are healthy diets? Joint statement by the Food and Agriculture Organization of the United Nations and the World Health Organization* (Geneva, 2024).

²²⁴ World Health Organization, ‘Malnutrition’ (*WHO*) <<https://www.who.int/news-room/factsheets/detail/malnutrition>> accessed 3 June 2022.

²²⁵ *ibid.*

²²⁶ *ibid.*

are also called “ready-to-eat and ready-to-heat,” are more affordable and accessible, especially to lower socioeconomic levels of society.²²⁷ This highlights a critical issue: unhealthy food is often cheaper and therefore more accessible than nutritious options.²²⁸

4.4 Physical inactivity

Finally, physical inactivity is also one of the leading causes of non-communicable diseases. According to the WHO, it increases by 20–30% the risk of cancer, heart disease, stroke, and diabetes.²²⁹ The WHO defines physical activity as any bodily movement produced by skeletal muscles that requires energy expenditure, for instance walking, cycling, wheeling, sports, active recreation, and play.²³⁰ It has been proven that being physically active helps prevent hypertension, maintain a healthy body weight, and improve mental health, quality of life, and well-being.²³¹ However, it is estimated that one in four adults and four out of five adolescents are insufficiently physically active.²³²

Physical inactivity highlights health inequalities in the population. Women, girls, and people of low socioeconomic position have less access to safe, accessible, affordable, and appropriate spaces and places to be physically active, so they are less active. Due to this lack of physical activity, the WHO has committed to reducing physical inactivity by 15% by 2030.²³³

Furthermore, according to a 2013 study analyzing the economic burden of physical inactivity across 142 countries, the costs of physical inactivity to healthcare systems internationally \$ (INT\$) were 53.8 billion worldwide, and physical inactivity was responsible for 13.4 million DALYs.²³⁴

Here, it is significant to mention the impact of urbanization as a contributor to physical inactivity. Since 2010, more people have lived in urban areas than in rural areas worldwide.²³⁵

²²⁷ Popkin and Ng, ‘The Nutrition Transition to a Stage of High Obesity’ (n 215).

²²⁸ UN General Assembly, ‘Report of the Special Rapporteur on the Right to Food, Olivier de Schutter : final report : the transformative potential of the right to food’ (24 January 2014) UN Doc A/HRC/16/49 para 30.

²²⁹ World Health Organization, ‘Physical Activity’ (*WHO*) <https://www.who.int/health-topics/physical-activity#tab=tab_2> accessed 3 June 2022.

²³⁰ *ibid.*

²³¹ *ibid.*

²³² *ibid.*

²³³ World Health Organization, *Global Action Plan on Physical Activity 2018–2030: More Active People for a Healthier World* (World Health Organization 2018).

²³⁴ Ding Ding and others, ‘The Economic Burden of Physical Inactivity: A Global Analysis of Major Non-Communicable Diseases’ (2016) 388 *The Lancet* 1311.

²³⁵ UN Conference on Trade and Development, *From the Handbook of Statistics to Data Insights* (UNCTADstat) <<https://hbs.unctad.org/total-and-urban-population/>> accessed 12 July 2022.

In 2020, 56.2% of the world population was urban, and this number is expected to increase in the next years.²³⁶ Urbanization is typically associated with improvements in population health, such as access to healthcare, clean water, and sanitation.²³⁷ However, urbanization has also negatively impacted health. In many countries, motorized transportation, such as cars, is the leading mode of transportation.²³⁸ This increased the sedentary behavior and consequently the physical inactivity of populations in developed and developing countries. For this reason, there is encouragement for active modes of transportation, such as cycling and walking.²³⁹

It is evident the importance of maintaining the body active for health and consequently to avoid NCDs. Nevertheless, physical inactivity has been much addressed by the food and sweetened beverage industry as the primary cause of obesity and non-communicable diseases. In 2013, Coca-Cola spent \$3.3 billion on advertising “all calories count”, suggesting that if you do sports, you can drink sweetened beverage drinks and still be “healthy”.²⁴⁰ Along the same lines, the fast-food company McDonald’s used “Ronald McDonald,” the mascot of the brand, to promote messages of living an active life and practicing physical activity.²⁴¹

Thus, it is crucial to make clear that pointing out physical inactivity as the only responsible factor for obesity and the associated non-communicable diseases is misguided. While physical activity is undoubtedly important, it is not the only factor at play.

II NCD risk distribution and social determinants of health

Non-communicable diseases do not affect all individuals equally. At every stage of life, there are risk factors that can negatively impact health, and these are closely linked to the broader social determinants of health.

The social determinants of health (SDH) refer to the conditions in which individuals are born, grow, live, work, and age.²⁴² These conditions are directly impacted by the distribution of

²³⁶ *ibid.*

²³⁷ Freudenberg, ‘Lethal but Legal’ (n 147) 39.

²³⁸ Mark J Nieuwenhuijsen and Haneen Khreis, ‘Transport and Health; an Introduction’ [2020] Elsevier eBooks 3.

²³⁹ *ibid.*

²⁴⁰ A Malhotra, T Noakes and S Phinney, ‘It Is Time to Bust the Myth of Physical Inactivity and Obesity: You Cannot Outrun a Bad Diet’ (2015) 49 *British Journal of Sports Medicine* 967.

²⁴¹ Freudenberg, ‘Lethal but Legal’ (n 147) 106.

²⁴² World Health Organization, ‘Social Determinants of Health’ (*WHO*) <https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1> accessed 21 June 2025.

money, power, and resources at global, national, and local levels and influence health inequalities.²⁴³

These determinants are widely recognized as fundamental drivers of health inequalities, as they influence individuals' access to opportunities and resources necessary for achieving and maintaining good health.²⁴⁴ Inequities in SDH are closely linked to structural factors such as gender, socioeconomic status, ethnicity, and disability, which together contribute to persistent disparities in health outcomes.²⁴⁵

These differences in health status are seen within and between countries.²⁴⁶ For instance, in Switzerland, which is considered a developed country, health inequalities related to NCDs are evident. A national report highlights that life expectancy varies significantly by place of residence, reductions in tobacco consumption differ depending on income, individuals with a migration background are less likely to access medical care, and people with lower levels of education eat less fruit and vegetables.²⁴⁷

Socioeconomic inequalities, in particular, play a critical role in shaping patterns of morbidity and mortality within and between countries. In the context of non-communicable diseases, health inequities often stem from differential exposure to adverse social determinants. Research has shown that SDH significantly influences the risk distribution of disability and premature mortality from NCDs by shaping the underlying behavioral risk factors.²⁴⁸

For example, educational level has been found to modify the relationship between household wealth and obesity, illustrating the complex interplay between different dimensions of social disadvantage.²⁴⁹ Moreover, early-life conditions, including poor nutrition and a lack of adequate care and stimulation, can limit children's developmental potential, entrenching health disparities from a young age and perpetuating cycles of inequality throughout the life course.²⁵⁰ In addition, children's diet choices are influenced by their family environment.²⁵¹

²⁴³ U.S Centers for Disease Control and Prevention, 'About Social Determinants of Health (SDOH)' (CDC 2020) <<https://www.cdc.gov/socialdeterminants/about.html>> accessed 9 August 2022.

²⁴⁴ The analysis of the social determinants of health will focus in the relation between NCDS impact and unhealthy diets.

²⁴⁵ Michael Marmot and Ruth Bell, 'Social Determinants and Non-Communicable Diseases: Time for Integrated Action' (2019) 364 BMJ.

²⁴⁶ WHO, 'Social Determinants of Health' (n 242).

²⁴⁷ Federal Office of Public Health, *Health Equity: Facts and Figures for Switzerland* (January 2018).

²⁴⁸ Marmot and Bell, 'Social Determinants and Non-Communicable Diseases' (n 245).

²⁴⁹ Ruth Bell and others, 'Chapter 17: Social Determinants of Health and NCDs' in Nick Banatvala and Pascal Bovet, *Noncommunicable Diseases: A Compendium* (Routledge 2023) 128.

²⁵⁰ *ibid.*

²⁵¹ Marmot and Bell, 'Social Determinants and Non-Communicable Diseases' (n 245).

The idea that individuals are free to make their dietary choices is not true. In reality, individual choices are shaped, and often, constrained by social, economic, environmental, political, and cultural factors.²⁵² These constraints are not uniformly distributed across the population, they vary according to individuals' social positions, including factors such as income, education, and place of residence.²⁵³ As a result, not everyone has equal access to healthy choices. For example, the affordability of nutritious food remains a significant barrier for many, particularly for low-income households, highlighting how structural determinants can limit the practical availability of healthier options.²⁵⁴

Finally, according to the Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/26/31, the probability of lower-income people living in “food deserts” (areas with limited access to fresh and healthy food options) or “food swamps” (overwhelming presence of unhealthy food and aggressive, unhealthy food marketing) is higher.²⁵⁵ This underscores the disparities in societies and illustrates that NCD risk is not simply a matter of individual behavior but is profoundly shaped by structural and social conditions.

²⁵² *ibid.*

²⁵³ *ibid.*

²⁵⁴ *ibid.*

²⁵⁵ UN General Assembly, ‘Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Tlaleng Mofokeng – Harm reduction for sustainable peace and development’ (18 July 2024) UN Doc A/79/177.

CHAPTER 2: THE NON-COMMUNICABLE DISEASE PANDEMIC AND THE AGENTS RESPONSIBLE FOR CREATING THE RISK FACTORS

I The process of globalization and the rise of NCDs in low- and middle-income countries

1 Preliminary remarks

First, non-communicable diseases were a problem in high-income countries. However, due to the process of globalization, the ultra-processed food industries are now present in LMICs. Thus, the poorest populations are eating what is considered an unhealthy diet (rich in sugar, salt, trans-fat, and saturated fat), which increases the rates of overweight and obesity and consequently the related NCDs. As a result, besides having high rates of infectious diseases, the developing countries faced what has been called the double burden of communicable diseases and non-communicable diseases.²⁵⁶

The process of globalization has shifted the diet patterns and the lifestyle in many countries. Highly processed foods have become more available and more affordable. First, the high-fat diet was considered a characteristic of wealthy nations. However, in 1980, international economic policies designed to promote the flow of capital and the rapid expansion of trade became a reality in national food systems.²⁵⁷ In addition, in 1990, international and global trade agreements allowed the fast growth of transnational food manufacturing, retailing, and fast-food chains worldwide.²⁵⁸ As a result, the nutrition transition occurred in middle- and low-income countries at a much faster rate than it happened in developed countries.²⁵⁹

2 Globalization and trade law

Globalization is characterized by the process of integration of the world economy, in which there is a movement of goods and services, capital, and technology.²⁶⁰ Trade liberalization is

²⁵⁶ World Health Organization, *The Double Burden: Emerging Epidemics and Persistent Problems. The World Health Report 1999* (Geneva, 1999).

²⁵⁷ Monteiro and others, 'Ultra-Processed Products Are Becoming Dominant in the Global Food System' (n 215).

²⁵⁸ *ibid.*

²⁵⁹ Corinna Hawkes and others, *Trade, Food, Diet, and Health: Perspectives and Policy Options* (Blackwell 2010) 27.

²⁶⁰ Soledad Cuevas García-Dorado and others, 'Economic Globalization, Nutrition and Health: A Review of Quantitative Evidence' (2019) 15 *Globalization and Health*.

seen as a facilitator in the process of rapid dietary change across the world.²⁶¹ Trade liberalization has reduced barriers to importation and exportation.²⁶² As a result, the availability of cheap vegetable oils increased the consumption of high-fat diets in low and middle-income countries.²⁶³ As an illustrative example, soybean oil accounted for 21% of consumption in developing countries at the end of the 1990s.²⁶⁴ Soybean oil is used in the hydrogenated form in processed foods, and this hydrogenation process results in trans-fat.²⁶⁵

It is imperative to mention the Uruguay Round of the General Agreement on Tariffs and Trade (GATT) from 1994, which included agriculture in global trade for the first time.²⁶⁶ Before that, food was usually excluded from negotiations at GATT.²⁶⁷ The Uruguay Round of the GATT in 1994 encouraged countries to open agri-food markets by reducing tariffs, non-tariff barriers, export subsidies, and domestic agricultural support.²⁶⁸ In addition to the Uruguay Round of the GATT, the World Trade Organization (WTO) created the perfect scenario for integrating national food markets.²⁶⁹

Another crucial point is the increase in Foreign Direct Investments (FDI) throughout the food supply chain. HAWKES defines FDI as a “*long-term investment by an enterprise in one country into an enterprise in another, in which the foreign enterprise becomes a foreign affiliate the parent (transnational) company*”.²⁷⁰ It is estimated that between 1990 and 2004, the FDI from food manufacturers in developed countries into developing countries more than tripled.²⁷¹ On a global scale, the most significant recipient of FDI was food processing, especially highly processed foods.²⁷² Thus, through FDI, the transnational corporations expanded very fast and solidified themselves in developing countries, making more processed foods available to more people.

²⁶¹ Corinna Hawkes, ‘The Influence of Trade Liberalisation and Global Dietary Change: The Case of Vegetable Oils, Meat and Highly Processed Foods’, in Corinna Hawkes and others, *Trade, Food, Diet and Health: Perspectives and Policy Options* (Wiley-Blackwell 2010).

²⁶² *ibid.*

²⁶³ Adam Drewnowski and Barry M Popkin, ‘The Nutrition Transition: New Trends in the Global Diet’ (2009) 55 *Nutrition Reviews* 31.

²⁶⁴ Corinna Hawkes, ‘Uneven Dietary Development: Linking the Policies and Processes of Globalization with the Nutrition Transition, Obesity and Diet-Related Chronic Diseases’ (2006) 2 *Globalization and Health* 4.

²⁶⁵ *ibid.*

²⁶⁶ Corinna Hawkes and others, ‘Linking Agricultural Policies with Obesity and Noncommunicable Diseases: A New Perspective for a Globalising World’ (2012) 37 *Food Policy* 343.

²⁶⁷ *ibid.*

²⁶⁸ *ibid.*

²⁶⁹ Hawkes, ‘Uneven Dietary Development’ (n 264).

²⁷⁰ *ibid.*

²⁷¹ Hawkes and others, *Trade, Food, Diet, and Health* (n 259) 44.

²⁷² Corinna Hawkes, ‘The Role of Foreign Direct Investment in the Nutrition Transition’ (2005) 8 *Public Health Nutrition* 357.

An additional aspect is the removal of communication barriers and accelerated access to Western media in developing countries, which means access to the advertisement of products such as soft drinks.²⁷³ Likewise, the appearance of modern supermarkets in LMICs allowed access to packaged foods, soft drinks, and other unhealthy commodities for a low price.²⁷⁴ As a result, currently, almost 80% of NCD-related deaths occur in LMICs.²⁷⁵

3 Nutrition transition to unhealthy diets

The process of globalization does not only concern economic globalization, but it has also exported some cultural changes, including the expansion of Western diets. Within this framework, the term “Coca-Colonization” represents the imposition of the American diet and culture into developing countries, where buying Western brands such as Coca-Cola and Pepsi-Cola, due to their added “value”, has been associated with higher social status in low-income countries.²⁷⁶ Currently, Mexico is the leading consumer of Coca-Cola worldwide.²⁷⁷

Mexico is a clear example of the impacts of globalization leading to a shift in population diets and, consequently, the increase in the rates of obesity, diabetes, and other non-communicable diseases. In the 1980s, the market integration between Mexico and the United States started, and in 1994, with the signature of the North American Free Trade Agreement (NAFTA), this process was boosted.²⁷⁸ The NAFTA is a trade agreement that allowed the United States to increase the foreign direct investment in Mexico as it helped to raise the exportation of (unhealthy) commodities and the establishment of transnational corporations.²⁷⁹

To illustrate, in 1994, the US exported approximately 50,000 metric tons of sugars and sweeteners to Mexico; in 2007, this number was nearly 950,000.²⁸⁰ Likewise, in five years, the FDI in the Mexican food and beverage industries went from 2,3 billion to 8,8 billion dollars.²⁸¹

²⁷³ Barry M Popkin, ‘The Nutrition Transition: An Overview of World Patterns of Change’ (2004) 62 *Nutrition Reviews*.

²⁷⁴ Barry M Popkin, Linda S Adair and Shu Wen Ng, ‘Global Nutrition Transition and the Pandemic of Obesity in Developing Countries’ (2012) 70 *Nutrition Reviews* 3.

²⁷⁵ David Reubi, Clare Herrick and Tim Brown, ‘The Politics of Non-Communicable Diseases in the Global South’ (2016) 39 *Health & Place* 179.

²⁷⁶ Paul Zimmet AM, ‘Globalization, Coca-Colonization and the Chronic Disease Epidemic: Can the Doomsday Scenario Be Averted?’ (2001) 249 *Journal of Internal Medicine* 17.

²⁷⁷ Katia S Mohindra, ‘Globalization and Global Health’ in Robin Haring and others (eds), *Handbook of Global Health* (Springer 2021).

²⁷⁸ Hawkes, ‘Uneven Dietary Development’ (n 264).

²⁷⁹ Freudenberg, ‘Lethal but Legal’ (n 147).

²⁸⁰ *ibid.*

²⁸¹ *ibid.*

NAFTA also affected food retailing in Mexico. As a result of the lowered tariff barriers, large multinational supermarkets, such as Walmart, moved into the country and quickly became dominant.²⁸² In 2005, Walmart controlled almost 20% of the country's retail market.²⁸³ Finally, NAFTA allowed the growth of multinational fast-food companies, such as McDonald's. In 1985, the first McDonald's opened in Mexico City, and in 2012, there were more than 500 McDonald's restaurants spread over the country.²⁸⁴ As a consequence of all of these practices, the food consumption in Mexico changed towards energy-dense, processed foods high in fats and sweeteners, and consequently, the incidence of obesity, diabetes, and other associated NCDs suffered an alarming increase in the country.

In conclusion, the key mechanisms that link globalization and the nutrition transition in developing countries are food trade; foreign direct investment; global food advertising, promotions, and marketing; food retail restructuring (especially the development of supermarkets); the emergence of global agribusiness and transnational food companies; development of global rules and institutions that govern the production (for instance, the WTO), urbanization and cultural change.²⁸⁵

In addition, income influences dietary habits. Populations with lower income tend to have less access to healthy foods because these are more expensive.²⁸⁶ Hence, non-communicable diseases are more than a public health matter; they are also human rights issues. The NCDs affect the poor populations more harshly, especially in developing countries. Taking into consideration the impact of NCDs in LMICs, the WHO has called attention to governments to invest in the prevention of cancer, diabetes, and cardiovascular diseases, and not just in infectious diseases. For years, the budget allocated to health issues in developing countries was focused on infectious diseases.²⁸⁷

Besides the problem of the high level of mortality, there is also an economic burden for LCIMs. Currently, 85% of NCDs' premature deaths (before the age of 70) occur in low- and middle-income countries.²⁸⁸ Premature deaths represent a significant economic loss to countries since

²⁸² *ibid.*

²⁸³ *ibid.*

²⁸⁴ *ibid.*

²⁸⁵ Hawkes, 'Uneven Dietary Development' (n 264).

²⁸⁶ Qiao and others, 'Global Burden of Non-Communicable Diseases' (n 52).

²⁸⁷ Olivia Heller and others, 'The Process of Prioritization of Non-Communicable Diseases in the Global Health Policy Arena' (2019) 34 *Health Policy and Planning* 370.

²⁸⁸ World Health Organization, *Saving Lives, Spending Less: The Case for Investing in Noncommunicable Diseases* (World Health Organization 2021).

the individuals who are dying are in the most productive economic years.²⁸⁹ In 2011, a study estimated that financial losses from non-communicable diseases to low- and middle-income countries (LMICs) could surpass US\$ 7 trillion from 2011-2025, representing an average of approximately US\$ 500 billion per year.²⁹⁰

II Risk-creating industries

1 Preliminary remarks

Non-communicable diseases are largely driven by behavioral risk factors associated with the consumption of harmful products, including tobacco, alcohol, and unhealthy food.²⁹¹ Therefore, it is essential to explore further the agents responsible for creating these risk factors.

Tobacco, its implications for non-communicable diseases, and the tobacco industry's activity to influence public health have already been vastly explored over the years.²⁹² The harmful use of alcohol and the alcohol industry are also a turbulent area that is gaining momentum.²⁹³ This thesis will focus on the key risk factor classified as "unhealthy diet" and the actors who trigger this behavior, represented mainly by the food and sweetened beverages industries. Hence, it is essential to make it clear that the broader topics explored in this thesis will have the lens focused on unhealthy food products and the activity of the food and sweetened beverage companies, not exploring in detail the consequences of the tobacco and alcohol industries.²⁹⁴

Also known as Big Food and Big Soda, major transnational companies are responsible for putting unhealthy products high in sugar, sodium, trans fat, and saturated fat on the market, which are also called unhealthy commodities.²⁹⁵

²⁸⁹ *ibid.*

²⁹⁰ David E Bloom and others, *From Burden to 'Best Buys': Reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries* (WHO 2011).

²⁹¹ The component of physical inactivity will be briefly explored as it overlaps with the element of unhealthy diets.

²⁹² Brownell and Warner, 'The Perils of Ignoring History' (n 30).

²⁹³ A Rob Moodie, 'Big Alcohol: The Vector of an Industrial Epidemic' (2014) 109 *Addiction* 525.

²⁹⁴ This research recognizes the importance of addressing the issue of harmful use of alcohol and the activity of the alcohol industry, but will not delve deeper into this. Although comparisons and analogies with the tobacco industry will be used throughout this thesis due to the adoption of similar strategies by both industries. Nonetheless, they receive a different legal.

²⁹⁵ Lacy-Nichols and others, 'Conceptualising Commercial Entities in Public Health' (n 39).

2 Big Food and Big Soda

Preliminary Remarks

In 2013, at the 8th Global Conference on Health Promotion, the director-general of the WHO called attention to the role of Big Food and Big Soda in the rise of noncommunicable diseases: *“it is not just Big Tobacco anymore. Public health must also contend with Big Food, Big Soda, and Big Alcohol. All of these industries fear regulation, and protect themselves by using the same tactics. Research has documented these tactics well. They include front groups, lobbies, promises of self-regulation, lawsuits, and industry-funded research that confuses the evidence and keeps the public in doubt. Tactics also include gifts, grants, and contributions to worthy causes that cast these industries as respectable corporate citizens in the eyes of politicians and the public. They include arguments that place the responsibility for harm to health on individuals, and portray government actions as interference in personal liberties and free choice.”*²⁹⁶

NESTLE defines Big Food as multinational food and beverage corporations with huge and concentrated market power.²⁹⁷ Big Food is constituted only by 10 companies: Nestlé, PepsiCo, Coca-Cola, Unilever, Danone, General Mills, Kellogg’s, Mars, Associated British Foods, and Mondelez.²⁹⁸ These companies represent the concentrated market power that controls most of the world’s food and beverage brands, and their primary aim is to ensure maximum profits. This concentration of the market results in asymmetrical power and information, where the producers have more political power and information than the consumers.²⁹⁹

Besides the political power, it is imperative to make a remark about the economic power of these corporations. Through the profits of their unhealthy products, it is estimated that in 2004, Coca-Cola spent US\$2.2 billion on advertising and other forms of promotion while PepsiCo invested US\$1.7 billion for the same ends.³⁰⁰ This amount represents more than the WHO’s annual budget.³⁰¹ Another illustrative example is the amount of money spent on campaigns for

²⁹⁶ ‘Opening Address by Dr Margaret Chan, Director-General, World Health Organization’ (2014) 29 Health Promotion International.

²⁹⁷ Stuckler and Nestle, ‘Big Food, Food Systems, and Global Health’ (n 28).

²⁹⁸ Anita Anna George, ‘An an Unwelcome Seat at the Table: The Role of Big Food in Public and Private Standard-Setting and Its Implications for NCD Regulation’ (2018) 18 QUT Law Review 156; Freudenberg, ‘Lethal but Legal’ (n 147).

²⁹⁹ *ibid.*

³⁰⁰ Geof Rayner and others, ‘Trade Liberalization and the Diet Transition: A Public Health Response’ (2006) 21 Health Promotion International 67.

³⁰¹ *ibid.*

a sugar-sweetened beverage tax in Richmond, California. While supporters invested US\$70,000, industry-funded opposition expended US\$2.5 million to block the new tax.³⁰²

Many of these companies' products are part of diets in high- and low-income countries. The marketing campaigns used by brands, such as Coca-Cola, made these products universal and accessible. As Andy Warhol exposed about the “democratizing” of Coca-Cola: “*You can be watching TV and see Coca-Cola, and you know that the President drinks Coke, Liz Taylor drinks Coke, and just think, you can drink Coke, too. A Coke is a Coke and no amount of money can get you a better Coke than the one the bum on the corner is drinking. All the Cokes are the same and all the Cokes are good. Liz Taylor knows it, the President knows it, the bum knows it, and you know it.*”³⁰³

Besides putting unhealthy products on the market, these industries also apply tactics to influence public health decision-making. Big Food uses tactics such as corporate political activities and lobbying against stricter regulations and for voluntary collaborations, such as PPPs for NCD prevention.³⁰⁴

Unlike infectious diseases, where the vectors of the diseases are biological, in the context of non-communicable diseases, the vectors of the diseases are the products of transnational corporations, such as tobacco, alcohol, and unhealthy food.³⁰⁵ The harms linked to commodities from industries have been called “industrial epidemics”.³⁰⁶ These industries have also been described as the “vectors” of the NCD epidemic.³⁰⁷ For example, the increase in ultra-processed products has contributed to the increase in obesity, diabetes, and other diet-related chronic diseases.³⁰⁸ Their most obvious role as disease vectors lies in the manufacture, sale, and marketing of products that are harmful to health.³⁰⁹

FREUDENBERG describes that in the economic system we live in today, there is a “hyperconsumption” of unhealthy products which are linked to premature mortality and preventable diseases.³¹⁰ This system is called the “Corporate Consumption Complex,” represented by a web of organizations that include global corporations that produce the goods

³⁰² Allen, ‘Commercial Determinants of Global Health’ (n 28).

³⁰³ Andy Warhol, *The Philosophy of Andy Warhol: from a to B and Back Again* (London Penguin 1997).

³⁰⁴ Part 3, Chapter 11, IV.

³⁰⁵ Katherine E Smith, Sarah Hill and C Bamba, *Health Inequalities: Critical Perspectives* (Oxford University Press 2016).

³⁰⁶ Toebes and Patterson, ‘Human Rights and Non-Communicable Diseases’ (n 38) 245.

³⁰⁷ Moodie and others, ‘Profits and Pandemics’ (n 34).

³⁰⁸ *ibid.*

³⁰⁹ *ibid.*

³¹⁰ Freudenberg, ‘Lethal but Legal’ (n 147) 97.

of the modern consumer economy, the retail conglomerates that sell their products, and the trade associations that represent them in the political arena.³¹¹ He calls attention to the fact that it operates at local and global levels, influencing the behaviors and lifestyles of consumers and the legislative decisions of governments, threatening the health of humanity.³¹²

Finally, the 2011 report of the UN Special Rapporteur on the Right to Health, submitted to the UN General Assembly, recognized the transnational corporations of the global food industry as “the primary driver of diet-related NCDs” that “negatively impact the enjoyment of the right to health.”³¹³

Corporate playbook

It has been underscored that Big Food followed the corporate playbook from the tobacco industry.³¹⁴ For instance, corporations have emphasized behavior change and individual responsibility as the leading causes of NCDs. McDonald’s, the second largest fast-food company in the world, claims that it offers available choices for consumers and abstains from responsibility. According to McDonald’s, it is the parents’ decision what their children eat.³¹⁵ However, in reality, this strategy blames the victims instead of recognizing that the root of the problem is the corporations that are the perpetrators of unhealthy lifestyles. Moreover, these same corporations invest enormous money to persuade people to buy their unhealthy products or, as Nicholas FREUDENBERG puts it, “lethal but legal products”.³¹⁶

In this line, it is imperative to highlight that these legal products are the result of a legitimate economic activity. Ultra-processed food, fast food, and sweetened beverages are legal but dangerous products to human health. It is possible to draw a parallel between the food industry and the pharmaceutical industry. For instance, medicines are under regulations, and access to the market is not as free and accessible as unhealthy food. Therefore, regulating the activity of the ultra-processed food and sweetened beverage industries should not be seen as an obstacle.

³¹¹ *ibid*, 95.

³¹² *ibid*.

³¹³ UN General Assembly, ‘Report of the Working Group on the Universal Periodic Review’ UNHRC 26th Session (7 April 2014) UN Doc A/HRC/26/3.

³¹⁴ Brownell and Warner, ‘The Perils of Ignoring History’ (n 30).

³¹⁵ Freudenberg, ‘Lethal but Legal’ (n 147) 104.

³¹⁶ *ibid*, 68.

Looking back, the food industry's strategies against the criticism of their unhealthy products have changed over the years. First, the position of the food industry was in denial.³¹⁷ Back then, the industries were harshly opposed to any scientific evidence relating their products to obesity and non-communicable diseases. See the example of the Sugar Industry between the 1960s and 1970s, legitimizing sugar as a healthy product and undermining any study that linked sugar to obesity or diabetes.³¹⁸ Along the same lines, in the 1990s, when evidence about the harmful effects of trans fat started to appear, the food industry strongly denied the claims that trans fats were harmful to health.³¹⁹

Afterward, the corporations relied on manipulation mechanisms through political donations and political influence to prevent or demoralize public health policies that would put their business interests at risk.³²⁰ In addition, they applied criticism to public health policies and litigation to defy these policies.³²¹ Moreover, the enterprises have used initiatives such as corporate social responsibility (CSR) to position themselves as public health leaders.³²²

However, the food industry cannot adopt a posture of denial and opposition as it did once since the harms of ultra-processed food and sugar-sweetened beverages are well-proven and established scientifically.³²³ This would represent a loss of credibility. Therefore, nowadays, corporations present themselves as “part of the solution”. In 2003, Kraft Foods was the first company to publicly recognize the food industry's role in the obesity problem.³²⁴

3 Commercial determinants of health

The social determinants of health have a direct effect on NCDs.³²⁵ In the context of non-communicable diseases, a crucial concept that has gained attention is the commercial determinants of health (CDoH).³²⁶ In 2024, WHO Europe affirmed that there is growing evidence of the negative impact of certain commercial sector activities on health, particularly

³¹⁷ Lacy-Nichols and Williams, ““Part of the Solution”” (n 35).

³¹⁸ Taubes, *Case against Sugar* (n 194).

³¹⁹ Nicholas Freudenberg and Sandro Galea, ‘The Impact of Corporate Practices on Health: Implications for Health Policy’ (2008) 29 *Journal of Public Health Policy* 86.

³²⁰ Lacy-Nichols and Williams, ““Part of the Solution”” (n 35).

³²¹ *ibid.*

³²² *ibid.*

³²³ *ibid.*

³²⁴ *ibid.*

³²⁵ See Part 1, Chapter 1, II NCD risk distribution and social determinants of health.

³²⁶ Melissa Mialon, ‘An Overview of the Commercial Determinants of Health’ (2020) 16 *Globalization and Health*.

driving NCDs, through promoting harmful products such as tobacco, ultra-processed foods, and alcohol, and employing various tactics to obstruct NCD policy implementation.³²⁷

A Lancet series underscored that just four industries (tobacco, ultra-processed food, fossil fuel, and alcohol) account for at least a third of global deaths, indicating the scale and huge economic cost of the problem.³²⁸ Commercial activity can impact human health directly and indirectly. The positive direct effects, such as pharmaceuticals, fruits, and vegetables, are well-known.³²⁹ The negative direct effects are also well known, such as buying and consuming products like cigarettes, handguns, and sugar-sweetened beverages. The negative indirect effects would be the spread of diseases along trading routes, environmental degradation, harmful working conditions, socioeconomic inequalities, and political lobbying.³³⁰

In addition, demerit goods and negative externalities are essential concepts for understanding the commercial determinants of health. Demerit goods are goods and services that result in physical or social consequences for the consumer, such as alcohol, tobacco, and ultra-processed foods.³³¹ Negative externalities represent an unfavorable outcome of an economic activity experienced by a party that was not directly involved in the activity, for instance, the consumer.³³²

The WHO defines CDoH as the “private sector activities impacting public health, either positively or negatively, and the enabling political-economic systems and norms”.³³³ Notwithstanding, there are a few definitions of commercial determinants of health. One definition would be that the CDoH is the factor that influences health that stems from the profit motive.³³⁴

KICKBUSCH has also described commercial determinants of health as strategies and approaches used by the private sector to promote products and choices that are damaging to health.³³⁵

³²⁷ World Health Organization Regional Office for Europe, Commercial Determinants of Noncommunicable Diseases in the WHO European Region (Copenhagen, WHO Regional Office for Europe 2024).

³²⁸ Anna B Gilmore and others, ‘Defining and Conceptualising the Commercial Determinants of Health’ (2023) 401 *The Lancet* 1194.

³²⁹ Allen, ‘Commercial Determinants of Global Health’ (n 28).

³³⁰ *ibid.*

³³¹ *ibid.*

³³² *ibid.*

³³³ World Health Organization, ‘Commercial Determinants of Health - Global’ (*WHO*) <<https://www.who.int/health-topics/commercial-determinants-of-health>> accessed 3 July 2022.

³³⁴ Robert West and Theresa Marteau, ‘Commentary on Casswell (2013): The Commercial Determinants of Health’ (2013) 108 *Addiction* 686.

³³⁵ Iлона Kickbusch, Luke Allen and Christian Franz, ‘The Commercial Determinants of Health’ (2016) 4 *The Lancet Global Health*.

Finally, the commercial determinants of health are grounded in the inherent tension between commercial and public health objectives.³³⁶ An illustration of this tension is the example of the determinants of noncommunicable diseases such as tobacco, alcohol, and unhealthy food products.³³⁷ The CDoH started with the problem of tobacco, but it has been expanded to other harmful commodities. For instance, Big Food has been linked to the contribution of high levels of obesity and diabetes.³³⁸

Recently, scholars highlighted the need for a broader concept for CDoH going beyond the “unhealthy products” sphere. Hence, a proposed concept would be “the commercial determinants of health as the social, political, and economic structures, norms, rules, and practices by which business activities designed to generate profits and increase market share influence patterns of health, disease, injury, disability, and death within and across populations.”³³⁹

In 2023, the Lancet published a series on the commercial determinants of health, which defined the term as “the systems, practices, and pathways through which commercial actors drive health and equity.”³⁴⁰ This definition highlights that there are different types of commercial entities, and they can contribute positively or negatively to human and planetary health.

This thesis will use the KICKBUSCH definition since it englobes consumer and health behavior, individualization, and choice (micro level), the global risk society, the global consumer society, and the political economy of globalization (macro level).³⁴¹ In addition, this thesis focuses on exploring the harms caused by the “unhealthy products” of transitional companies (especially unhealthy food and sweetened beverages). Following KICKBUSCH’s lesson about CDoH, there are four channels through which transnational corporations influence health: marketing, lobbying, corporate social responsibility schemes, and extensive supply chains.³⁴²

Furthermore, the commercial determinants in the context of dietary behaviors associated with obesity have been defined as “strategies used by the food industry to create a favorable regulatory and discursive environment in which they can produce, promote and increase sales

³³⁶ Katherine Robaina and others, ‘Alcohol Industry Actions to Reduce Harmful Drinking in Europe: Public Health or Public Relations?’ (2018) 04 Public Health Panorama 341.

³³⁷ *ibid.*

³³⁸ Stuckler and Nestle, ‘Big Food, Food Systems, and Global Health’ (n 28).

³³⁹ Nicholas Freudenberg and others, ‘Defining Priorities for Action and Research on the Commercial Determinants of Health: A Conceptual Review’ (2021) 111 American Journal of Public Health 2202.

³⁴⁰ Gilmore and others, ‘Defining and Conceptualising the Commercial Determinants of Health’ (n 328).

³⁴¹ Kickbusch, Allen and Franz, ‘The Commercial Determinants of Health’ (n 335).

³⁴² *ibid.*

of their products to maximize profits and generate continued shareholder value”.³⁴³ In this framework, the strategies would work through 3 different spheres: political and legal, production, processing, design, and marketing and preference shaping.³⁴⁴ These strategies include lobbying, FDI, neoliberal economic policies, CSR, strong advertising, funding biased research, and others. These strategies have also been called practices of power exercised by corporations.³⁴⁵

The commercial determinants of health are a relatively new concept. Thus, academics call attention to the need to develop this approach and the need for a consensus on the definition to evolve effective public health interventions in the prevention of NCDs.³⁴⁶ Along these lines, the Vienna Declaration on Public Health reiterated principles of the Ottawa Charter, recognizes the growth of the role of non-state actors, and highlights the importance of distinguishing “those that pursue public interest objectives from those that pursue commercial interests”.³⁴⁷ Moreover, the WHO has started to address this topic. The Department of Social Determinants created a program of work called Economic and Commercial Determinants of Health, which aims to strengthen the evidence base on the topic, develop tools and capacity to address the commercial determinants, organize partnerships and dialogue, and raise awareness and advocacy.³⁴⁸

In conclusion, an expanding body of scholarship highlights the commercial determinants of health, shedding light on how corporate practices shape environments and industry strategies

³⁴³ Yanaina Chavez-Ugalde and others, ‘Conceptualizing the Commercial Determinants of Dietary Behaviors Associated with Obesity: A Systematic Review Using Principles from Critical Interpretative Synthesis’ (2021) 7 *Obesity Science & Practice* 473.

³⁴⁴ *ibid.*

³⁴⁵ Joana Madureira Lima and Sandro Galea, ‘Corporate Practices and Health: A Framework and Mechanisms’ (2018) 14 *Globalization and Health*.

³⁴⁶ Kelley Lee and Nicholas Freudenberg, ‘Addressing the Commercial Determinants of Health Begins with Clearer Definition and Measurement’ (2020) 27 *Global Health Promotion* 3; Nicholas Freudenberg and others, ‘Defining Priorities for Action and Research on the Commercial Determinants of Health: A Conceptual Review’ (2021) 111 *American Journal of Public Health* 2202; Cassandra de Lacy-Vawdon and Charles Livingstone, ‘Defining the Commercial Determinants of Health: A Systematic Review’ (2020) 20 *BMC Public Health*.

³⁴⁷ “It is essential to recognize the growing role of diverse non-state actors, and especially the importance of distinguishing those that pursue public interest objectives from those that pursue commercial interests, paying particular attention to the difficulties that can arise with activities promoted as corporate social responsibility.” European Public Health Association. The European Public Health Association and the Austrian Public Health Association, *Vienna Declaration: Building Forward Better – Towards a Fairer, Greener and Healthier Future for All* (2022) <https://ephconference.eu/repository/publications/Vienna_Declaration_final_version.pdf> accessed 01 August 2022.

³⁴⁸ World Health Organization, ‘Commercial Determinants of Health’ (*WHO*) <<https://www.who.int/news-room/fact-sheets/detail/commercial-determinants-of-health>> accessed 9 August 2022.

that contribute to the rising burden of NCDs.³⁴⁹ Nonetheless, the translation of this scientific evidence into the legal and regulatory sphere has been comparatively slow.

³⁴⁹ Nason Maani, Mark Petticrew and Sandro Galea, *The Commercial Determinants of Health* (Oxford University Press 2022); Crosbie and Carriedo, 'Applying a Commercial Determinants of Health Lens' (n 35); Mialon, 'An Overview of the Commercial Determinants of Health' (n 326); Buse, Tanaka and Hawkes, 'Healthy People and Healthy Profits?' (n 35); Sanjay Kalra, Madhur Verma and Nitin Kapoor, 'Commercial Determinants of Health: A Critical Component of the Obesogenic Environment' (2023) 23 *Clinical Epidemiology and Global Health* 101367; Martin McKee and David Stuckler, 'Revisiting the Corporate and Commercial Determinants of Health' (2018) 108 *American Journal of Public Health* 1167; Kelley Lee and Nicholas Freudenberg, 'Public Health Roles in Addressing Commercial Determinants of Health' (2022) 43 *Annual Review of Public Health* 375; Sharon Friel and others, 'Commercial Determinants of Health: Future Directions' (2023) 401 *The Lancet* 1229.

CHAPTER 3: PUBLIC HEALTH, NCD PREVENTION, AND THE LAW

I Notion of public health

Public Health is considered an empirical and multidisciplinary field whose goal is to ensure conditions in which people can be healthy.³⁵⁰ Different from medicine, where the primary focus is on treating illness in separate individuals, the vital aim of public health is to increase health at the population level. Public Health interventions include preventive, curative, and rehabilitative actions such as community hygiene, sanitation, health education, immunization, and promotion of nutrition.³⁵¹

The WHO defined public health as “all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases.”³⁵²

Thus, the focus of public health is prevention.³⁵³ Prevention has been described as “interventions to reduce risk or avert harm from injury and disease”.³⁵⁴ The approaches in public health have been described as downstream and upstream interventions. The focus of the downstream approach is the individual. In contrast, the upstream is a population-based approach that targets the underlying determinants and root causes of health problems (focusing on social, political, and economic contexts).³⁵⁵ In the context of NCDs, downstream interventions are represented mostly by behavior change and education to promote healthier lifestyles, such as labeling, media campaigns, nudging, and voluntary reformulation (through public-private partnerships, for example).³⁵⁶ However, this approach depends on the individual response, and

³⁵⁰ Natalie M Schmitt and Jochen Schmitt, ‘Definition of Public Health’ [2008] *Encyclopedia of Public Health* 222.

³⁵¹ *ibid.*

³⁵² John Coggon, Keith Syrett and AM Viens, *Public Health Law: Ethics, Governance, and Regulation* (Routledge 2016).

³⁵³ Lawrence O Gostin and Lindsay F Wiley, *Public Health Law: Power, Duty, Restraint* (University of California Press 2016) 90. It is crucial to underscore that the landscape of public health law comprises a spectrum of legal frameworks and regulations, ranging from those addressing infectious diseases to those governing environmental health factors such as air and water quality, waste management, and sanitation, as well as safety measures, among others. However, given the specific focus of this research on non-communicable diseases, the attention will be to public health law concerning NCD prevention.

³⁵⁴ *ibid.*, 5.

³⁵⁵ Rob Ralston, Charlotte Godziewski and Lauren Carters-White, ‘The Many Meanings of Policy Instruments: Exploring Individual and Structural Determinants in Obesity Policy’ (2023) 51 *Policy & Politics* 1.

³⁵⁶ L Hyseni and others, ‘The Effects of Policy Actions to Improve Population Dietary Patterns and Prevent Diet-Related Non-Communicable Diseases: Scoping Review’ (2016) 71 *European Journal of Clinical Nutrition* 694.

it has been pointed out that downstream approaches widen the inequalities in society.³⁵⁷ The upstream approach is done at the population level, through structural intervention, represented by regulation, mandatory reformulation, subsidies, and taxation.³⁵⁸

II Public health law

1 Definition

Public health law has been defined as “the field of study and practice that concern those aspects of law, policy and regulation that advance or place constraints upon the protection and promotion of health (howsoever understood) within between and across populations”.³⁵⁹

The most famous definition of public health law is the one from GOSTIN: “Public health law is the study of the legal powers and duties of the state to ensure the conditions for people to be healthy (to identify, prevent, and ameliorate risks to health in the population) and the limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, or other legally protected interests of individuals for the common good. The prime objective of public health law is to pursue the highest possible level of physical and mental health in the population, consistent with the values of social justice”.³⁶⁰

In the early 2000s, the concerns surrounding obesity and unhealthy diets started to gain attention within the realm of public health.³⁶¹ This period marked the emergence of what scholars have termed the “new public health movement” and “new frontier of public health law”, characterized by a paradigm shift towards the focus on non-communicable diseases, emphasizing risk regulation and the promotion of “healthier lifestyles”.³⁶² This transformative movement redefined the function of law within public health and its potential as a tool for

³⁵⁷ Rory McGill and others, ‘Are Interventions to Promote Healthy Eating Equally Effective for All? Systematic Review of Socioeconomic Inequalities in Impact’ (2015) 15 BMC Public Health.

³⁵⁸ Martin Caraher, Sinéad Furey and Rebecca Wells, *Food Policy in the United Kingdom* (Routledge 2023).

³⁵⁹ John Coggon, Keith Syrett and AM Viens, *Public Health Law: Ethics, Governance, and Regulation* (Routledge 2016) 16.

³⁶⁰ Gostin and Wiley, *Public Health Law: Power, Duty, Restraint* (n 353) 4.

³⁶¹ Richard A Epstein, “In Defense of the ‘Old’” Public Health: the Legal Framework for the Regulation of Public Health,” 69 Brooklyn Law Review 1421 (2004). Before public health law primary focus revolved around the control of infectious diseases, commonly referred to as the “old public health law.” This entailed measures such as compulsory vaccination, isolation, and quarantines, which served as key examples.

³⁶² Michelle M Mello, David M Studdert and Troyen A Brennan, ‘Obesity — the New Frontier of Public Health Law’ (2006) 354 New England Journal of Medicine 2601; Lindsay F Wiley, ‘Rethinking the New Public Health’ (2012) 69 Washington and Lee Law Review.

advancing public health objectives.³⁶³ Nevertheless, the regulatory measures aimed at promoting public health often intersect with private behaviors, prompting the emergence of criticisms regarding paternalism.³⁶⁴

In the field of NCD prevention, the role of law is perceived as an instrument or tool for promoting and safeguarding health. Consequently, public health law comprehends traditional legal functions and policy processes, granting governments with the authority and scope of power to enhance the health of the population.³⁶⁵

2 Regulatory approaches

The field of public health law includes legal mechanisms and regulatory strategies to advance the overall health of the population. GOSTIN presents a taxonomy of these modes of legal intervention to advance the public's health and safety: direct regulation, indirect regulation through taxation and spending, indirect regulation through tort liability, and deregulation.³⁶⁶

Direct regulation is mostly characterized by command-and-control regulation, which has been described as “highly “hierarchical, state-centric, bureaucratic, top-down, and expert-driven”.”³⁶⁷

More focused on the American context and the outcomes of the exercise of legal and executive power, GOSTIN categorizes public health interventions as the power to tax and spend, the power to alter the information environment, the power to alter the built environment, the power to alter the socioeconomic environment, direct regulation of persons, professionals, and business, indirect regulation through the tort system, deregulation.³⁶⁸ Nevertheless, these public health interventions can be applied to different countries.

In the context of unhealthy diets, the power to tax, the power to alter the built environment, and the power to alter the information environment are examples of interventions used. For instance, “sin taxes” or “fat taxes” are taxation measures for high-calorie foods. Under the category of “alter the information environment” are measures to encourage people to make healthier

³⁶³ *ibid.*

³⁶⁴ This aspect will be examined in detail in Part 2, Chapter 8, II The prevention state and paternalism critique.

³⁶⁵ Maddie Heenan and others, ‘Legal and Regulatory Instruments for NCD Prevention: A Scoping Review and Descriptive Analysis of Evaluations in OECD Countries’ (2024) 24 BMC Public Health.

³⁶⁶ Gostin and Wiley, *Public Health Law: Power, Duty, Restraint* (n 353) 27-28.

³⁶⁷ *ibid.*, p 201.

³⁶⁸ *ibid.*, p 27-33.

choices, such as communication campaigns, labelling, and regulation of advertising unhealthy products.³⁶⁹

The regulatory approaches can also be classified as regulation, co-regulation, quasi-regulation, and self-regulation. Regulation is when the government (solely) develops, administers, and enforces the regulation. Co-regulation is when industry and government jointly develop, administer, and enforce a regulatory regime; for instance, governments prescribe self-regulation but allow industry to establish terms, which means that it delegates power to industry to regulate and enforce codes. Quasi-regulation happens when the government influences the development and implementation of self-regulation without using legislation; for example, the government threatens the industry with legislation or points to the existence of self-regulation as justification for not regulating. Finally, self-regulation is when the industry formulates rules and codes of conduct, and the industry is uniquely responsible for enforcement.³⁷⁰

Finally, GOSTIN presents the idea of analyzing regulatory approaches on a spectrum from heavily prescriptive and coercive interventions (command-and-control regulation) to a level of almost non-interference (voluntarism and self-regulation) and the regulatory approaches in between (indirect modes of regulation, such as tort liability and taxation).³⁷¹

Public health strategies for preventing non-communicable diseases raise complex legal and philosophical questions, particularly regarding the balance between autonomy and state intervention.³⁷² On the objection of regulation for NCD prevention, frequently invoked arguments are individual rights and liberties, premised on the notion that lifestyle choices are personal matters.³⁷³

CONCLUDING REMARKS ON PART 1

This first part has introduced the critical importance of legally addressing non-communicable diseases. It began by presenting the four major NCDs and identifying the primary risk factors associated with their development, with a particular focus on unhealthy diets. This part also

³⁶⁹ *ibid*, 28-30.

³⁷⁰ Heenan and others, 'Legal and Regulatory Instruments for NCD Prevention' (n 365).

³⁷¹ Gostin and Wiley, *Public Health Law: Power, Duty, Restraint* (n 353) 200.

³⁷² *ibid*, 34-36.

³⁷³ Peter-Spiess, *Food Regulation and Public Health* (n 16) 76.

highlighted the role of globalization in accelerating changes to dietary patterns and facilitating the global spread of diet-related NCDs, turning them into a pressing international concern.

This part underscored that the NCD risk distribution is shaped by social and commercial determinants of health. Thus, unhealthy diets are not merely a matter of individual responsibility but are significantly shaped, and often constrained, by structural factors beyond individual control and influenced by “risk-creating” industries, often referred to as Big Food and Big Soda, which play a central role in shaping contemporary food environments. Through their unhealthy products and practices, these industries create the risk for developing NCDs.

This context provides a critical lens for understanding the role of public health regulation in addressing food products and the activities of the food industry. It finishes by introducing the field of public health law and the regulatory approaches used for NCD prevention. It establishes the importance of tackling this “silent” pandemic and sets the stage for exploring the regulatory responses, legal frameworks, and public-private partnerships analyzed in the subsequent part of this thesis.

PART 2

**PUBLIC HEALTH LEGAL RESPONSES TO NON-COMMUNICABLE DISEASES
PREVENTION**

As NCDs have emerged as a leading cause of death globally and a major economic burden on health systems, various legal responses have been developed at the international, regional, and domestic levels for NCD prevention. This part aims to explore the current legal framework to tackle non-communicable diseases, with particular attention to how it has created the conditions for private sector involvement through public-private partnerships.

First, it will begin by presenting the normative foundation in the context of NCDs, through a global health law approach elucidating the right to health and the right to adequate food. Then it will map public health legal responses at the international level, which are represented predominantly in soft law instruments. A similar pattern is observed at the regional level, where legal responses also emphasize non-binding frameworks and the promotion of cross-sector collaboration, often explicitly encouraging the formation of PPPs. At the domestic level, regulatory action for NCD prevention is frequently limited by concerns about paternalism and the idea of “new governance”, resulting in the creation of voluntary measures.

Understanding the current legal framework is essential to contextualize the rise of PPPs as an alternative regulatory approach for NCD prevention. This framework is characterized by a reliance on soft law instruments at the international level and encouragement of private sector engagement. It is influenced by the theory of “new governance,” and driven by the idea that voluntary approaches may be quicker and more effective than traditional regulation. Moreover, it is shaped by neoliberal ideals, including the emphasis on “individual responsibility” and paternalistic critiques of command-and-control regulations.

CHAPTER 4: NORMATIVE FRAMEWORK GOVERNING NCD PREVENTION

I Preliminary remarks

First, to better understand the legal instruments used as public health tools for the prevention of non-communicable diseases, this part presents the relevant normative framework. It begins with an overview of global health law before examining the human right to health and the right to adequate food as key normative foundations for public health responses at international and domestic levels. Finally, it will explore the interconnections between different legal regimes, particularly the intersection of international trade law and public health.

II Global health law

In the context of public health responses to NCD prevention, it is essential to address global health law to understand the development of PPP for NCD prevention. Global health law has been described as a branch of international law, or as being situated within public health law.³⁷⁴

GOSTIN defines global health law as the study and practice of hard law and soft instruments that shape norms, processes, and institutions to attain the highest attainable standard of physical and mental health for the world's population.³⁷⁵ It has also been defined as the set of binding and non-binding instruments adopted in the framework of the WHO in interaction with other fields of international law, such as human rights law, international humanitarian law, international environmental law, international trade, and property and investment law.³⁷⁶

A key concept is global health governance, which is the collection of rules, norms, institutions, and processes that shape the health of the world's population.³⁷⁷ GOSTIN adds that the goal of governance strategies is to organize divergent stakeholders and manage social, economic, and political issues in order to improve global health.³⁷⁸ Moreover, global health governance encompasses different areas, such as agriculture, trade, development, human rights, and the environment, as well as various stakeholders such as civil society, philanthropic organizations,

³⁷⁴ Brigit Toebes, 'Global Health Law as a Foundation for NCD Prevention — a Statement from a Believer' (2025) 53 *Journal of Law, Medicine & Ethics* 29.

³⁷⁵ Gostin, *Global Health Law* (n 3) 59.

³⁷⁶ Brigit Toebes, 'Chapter 1: Global Health Law: Defining the Field' in Gian Luca Burci and Brigit Toebes (eds) *Research Handbook on Global Health Law* (Edward Elgar Publishing 2018) 2.

³⁷⁷ Gostin, *Global Health Law* (n 3) 71.

³⁷⁸ Gostin, *Global Health Law* (n 3) 72.

multilateral organizations, and industry.³⁷⁹ The universal values of good governance are honesty, transparency, deliberative decision-making, efficiency, and accountability.³⁸⁰ Finally, global health law can be perceived as a tool of global governance.³⁸¹

According to GOSTIN, the three main sources of global health law are international health law, the human right to health, and interconnecting legal regimes that impact health.³⁸²

International health law mostly includes the WHO normative standards. The WHO is the UN's specialized agency for health-related topics. The WHO Constitution gives the World Health Assembly (WHA) normative powers to adopt three types of instruments. First, Art. 19 grants the WHA power to adopt conventions or agreements (binding international treaties) with respect to any matter within the competence of the Organization.³⁸³ Secondly, Art.21 gives the WHA authority to adopt regulations concerning five specific health-related topics.³⁸⁴ However, until today, the WHA has only adopted three legally binding instruments: two regulations (the Nomenclature Regulations and the International Health Law Regulations) and one convention (the FCTC). Hence, the WHO mainly exercises normative authority through soft power.

Art. 23 of the WHO Constitution states that the WHA has the authority to make non-binding recommendations to members with respect to any matter within the competence of the Organization.³⁸⁵ Even though these recommendations are voluntary, Art. 62 requests States to report annually on compliance.³⁸⁶ One of the most notorious recommendations is the International Code of Marketing of Breast-Milk Substitutes (1981), which the WHA adopted in 1981.³⁸⁷

The WHO has also adopted a human-rights-based approach to health. Since HIV/AIDS, the WHO has included human rights in its policies. However, this approach is lacking in the context of NCD prevention. In 2019, scholars called for urgent human rights guidance on diets and food

³⁷⁹ *ibid.*

³⁸⁰ It is important to keep in mind these values for later analysis of the establishment of public-private partnerships with the food and sweetened beverage industry in the context of NCD prevention.

³⁸¹ Suerie Moon, 'Chapter 2: Global Health Law and Governance: Concepts, Tools, Actors and Power' in Gian Luca Burci and Brigit Toebes (eds), *Research Handbook on Global Health Law* (Edward Elgar Publishing 2018) 36.

³⁸² Gostin, *Global Health Law* (n 3) 12.

³⁸³ World Health Organization, *Constitution of the World Health Organization* (WHO 1989).

³⁸⁴ *ibid.*

³⁸⁵ *ibid.*

³⁸⁶ *ibid.*

³⁸⁷ World Health Organization, *The International Code of Marketing of Breast-Milk Substitutes* (Gardners Books 1996).

systems to create healthier food environments, mobilize multisectoral action, and strengthen State and private sector accountability.³⁸⁸

The second main source of global health is the human right to health, which will be elucidated next. Finally, the third main source would be the interconnecting legal regimes that impact health. The interconnecting legal regimes are extremely relevant to this research. Trade liberalization has a direct effect on increasing unhealthy food (the risk factor in the analyses in this research).³⁸⁹ In addition, legal measures to reduce the consumption of unhealthy products can affect international trade rules.³⁹⁰

III Human rights as a justification underlying NCD prevention

As TOEBES and PATTERSON affirmed, NCDs are perceived as a human rights issue.³⁹¹ States have a specific and continuing obligation toward the full realization of the right to health and other health-related human rights.³⁹² Thus, to understand the normative foundation for the adoption of legal instruments in public health, it is imperative to elucidate two human rights. First, the human right to health serves as a legal basis for measures adopted by States to NCD prevention, such as taxation, restrictions on marketing, and front-of-package nutrition labelling. Second, in the scope of NCDs, the right to adequate food is also crucial.

1 The right to health: normative justification

1.1 Historical evolution

Nowadays, the human right to health is well established in international treaties, regional instruments, and domestic constitutions, creating a normative foundation of global health law.

³⁸⁸ BMJ, ‘Urgent Call for Human Rights Guidance on Diets and Food Systems’ (*BMJ* 2019) <<https://blogs.bmj.com/bmj/2019/10/30/urgent-call-for-human-rights-guidance-on-diets-and-food-systems/>> accessed 3 June 2025.

³⁸⁹ See Part 1, Chapter 2, I, 2 Globalization and trade law.

³⁹⁰ Jonathan Liberman, ‘Making Effective Use of Law in the Global Governance of NCD Prevention’ in Tania Voon, Andrew Mitchell and Jonathan Liberman (eds), *Regulating Tobacco, Alcohol and Unhealthy foods: the Legal Issues* (Routledge 2014) 12.

³⁹¹ Toebes and Patterson, ‘Human Rights and Non-Communicable Diseases’ (n 38) 243.

³⁹² *ibid.*

For instance, every State has ratified at least one international human rights treaty recognizing the right to health.³⁹³

In the UN System, the right to health was first introduced as a normative standard in the WHO Constitution. The WHO Constitution, adopted in 1946, defined “health” in its preamble as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.³⁹⁴ Furthermore, the preamble recognizes the right to health as a fundamental right.³⁹⁵

In addition, in 1948, the Universal Declaration of Human Rights (UDHR) included the right to health as part of the right to an adequate standard of living.³⁹⁶ It is essential to highlight that under the international law positivist approach, the UDHR is not considered a treaty, it is a UN General Assembly resolution that lacks the formal force of law.³⁹⁷ However, the UDHR comprehends a basic set of rights that are incorporated into treaties, such as the right to health.³⁹⁸

In 1966, the United Nations General Assembly adopted the International Covenant on Economic, Social, and Cultural Rights (ICESCR).³⁹⁹ Art. 12 of the ICESCR sets out the core formulation of the right to health, and it is considered the most comprehensive article on the right to health in international human rights law.⁴⁰⁰ The ICESCR is a convention with binding status for all the parties that ratified it.

³⁹³ Office of the United Nations High Commissioner for Human Rights and World Health Organization, ‘Fact Sheet No. 31: The Right to Health’ (OHCHR 2008).

³⁹⁴ WHO, *Constitution of the World Health Organization* (n 383).

³⁹⁵ *ibid*, “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”.

³⁹⁶ Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. UN General Assembly, *Universal Declaration of Human Rights 1948* art 25 <<https://www.un.org/en/about-us/universal-declaration-of-human-rights>> accessed 3 June 2025.

³⁹⁷ Gostin, *Global Health Law* (n 3) 250.

³⁹⁸ *ibid*.

³⁹⁹ International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3.

⁴⁰⁰ *Ibid*, art 12.

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - (b) The improvement of all aspects of environmental and industrial hygiene;
 - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Since then, a few international human rights treaties have recognized the right to the “highest attainable standard of health” for specific groups, such as the International Convention on the Elimination of All Forms of Racial Discrimination: Art. 5 (e) (iv)⁴⁰¹, the Convention on the Rights of the Child⁴⁰², the Convention on the Elimination of All Forms of Discrimination against women⁴⁰³ and the Convention on the Rights of Persons with Disabilities.⁴⁰⁴

Finally, the Declaration Alma-Ata adopted in 1978 “strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector”.⁴⁰⁵ Thus, the right to health is considered a fundamental right and is also classified as an economic and social right.

In 2000, the Committee on Economic, Social, and Cultural Rights (CESCR) adopted General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), which can be considered an interpretation of the core features of the right to health.⁴⁰⁶ According to General Comment 14, the right to health comprises obligations and the realization of other human rights that contribute to health.⁴⁰⁷

In 2002, the Commission of Human Rights created the mandate of Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health.⁴⁰⁸ Since then, the Special Rapporteur has submitted annual thematic reports and reports on country missions. For instance, in 2014, the A/HRC/26/31 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health:

⁴⁰¹ International Convention on the Elimination of All Forms of Racial Discrimination (adopted 7 March 1966, entered into force 4 January 1969) 660 UNTS 195.

⁴⁰² Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3 art 24.

⁴⁰³ Convention on the Elimination of All Forms of Discrimination Against Women (adopted 18 December 1979, entered into force 3 September 1981) 1249 UNTS 13 art 11(1)(f), 12 and 14(2)(b).

⁴⁰⁴ Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) 2515 UNTS 3 art 25.

⁴⁰⁵ United Nations Children’s Fund, Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR (WHO 1978).

⁴⁰⁶ UN Committee on Economic, Social and Cultural Rights, ‘General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)’ (11 August 2000) UN Doc E/C.12/2000/4.

⁴⁰⁷ *ibid.*

⁴⁰⁸ UN Commission on Human Rights, ‘The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health’ (22 April 2002) UN Doc E/CN.4/RES/2002/31.

Unhealthy foods, non-communicable diseases and the right to health was issued, which draws links between unhealthy foods and diet-related non-communicable diseases.⁴⁰⁹

Besides the international framework, the right to health has also been recognized in the regional system through treaties. Art. 16 of the African Charter on Human and Peoples' Rights (1981) affirms that every individual shall have the right to enjoy the best attainable state of physical and mental health.⁴¹⁰ The Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights, known as the Protocol of San Salvador (1988), makes the same provision in Art. 10.⁴¹¹ Also, the European Social Charter (1961, revised in 1996) stipulates in Art. 11 the right to protection of health.⁴¹²

Finally, the right to health is also recognized in at least 115 constitutions, and at least six other constitutions provide duties to States regarding health, such as allocating a specific budget to health services.⁴¹³

1.2 Definition and guiding principles of the right to health

One of the main key factors to understanding the right to health is that “the right to health is not to be understood as a right to be healthy”.⁴¹⁴ In addition, the right to health is not limited to the right to healthcare. According to General Comment 14, the right to health is an inclusive right since Art. 12.2 mentions socio-economic factors associated with promoting a healthy lifestyle and includes the “underlying determinants of health” such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.⁴¹⁵

The right to health includes freedoms such as control of one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as torture, non-consensual medical treatment, and experimentation.⁴¹⁶ It also contains entitlements. For

⁴⁰⁹ UN General Assembly, ‘Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover : unhealthy foods, non-communicable diseases and the right to health’ (1 April 2014) UN Doc A/HRC/26/31.

⁴¹⁰ African Charter on Human and Peoples' Rights (adopted 27 June 1981, entered into force 21 October 1986) (1982) 21 ILM 58 (African Charter).

⁴¹¹ Organization of American States, *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights* (Protocol of San Salvador, 1999).

⁴¹² European Social Charter (adopted 18 October 1961, entered into force 26 February 1965) ETS No 35.

⁴¹³ OHCHR and WHO, ‘Fact Sheet No. 31’ (n 393).

⁴¹⁴ CESCR, ‘*General Comment No. 14*’ UN Doc E/C.12/2000/4 (n 406) para 8.

⁴¹⁵ *ibid*, para 4.

⁴¹⁶ *Ibid*, para 8.

instance, the right to a system of health protection which provides equality of opportunity for everyone to enjoy the highest attainable level of health.⁴¹⁷ Finally, the entitlement of every individual to the right to health is not a right to be guaranteed a level of health by the State per se, but an entitlement to enjoy the conditions which will maximize the potential for individuals to enjoy health.⁴¹⁸

One of the guiding principles of the right to health is the “Availability, Accessibility, Acceptability, and Quality” of health services and medicines (the AAAQ framework). Availability means that public health and healthcare facilities, goods, and services must be available in sufficient quantity.⁴¹⁹ The facilities, goods, and services have to be accessible to everyone without discrimination, and accessibility has four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility.⁴²⁰ Also, all health facilities, goods, and services must be acceptable, including ethically, culturally, and gender-sensitive.⁴²¹ Finally, health facilities, goods, and services must be of good quality and scientifically and medically appropriate.⁴²²

The right to health is considered normative and instrumental. From the normative perspective, the definition of the right to health is found in the first part of Art. 12 of the ICESCR. Whereas Art. 12.2 ICESCR enumerates illustrative, non-exhaustive examples of States parties’ obligations.⁴²³

General Comment 14 emphasizes that the progressive realization indicates that States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of everyone’s right to the enjoyment of the highest attainable standard of physical and mental health.⁴²⁴ Finally, despite resource constraints and progressive realization, certain health obligations are of immediate effect, such as the minimum core obligations.⁴²⁵

⁴¹⁷ *ibid.*

⁴¹⁸ John Tobin and Damon Barrett, ‘Chapter 3: the Right to Health and Health-Related Human Rights’ in Lawrence O Gostin and Benjamin Mason Meier (eds), *Foundations of Global Health & Human Rights* (Oxford University Press 2020) 68.

⁴¹⁹ CESCR, ‘*General Comment No. 14*’ UN Doc E/C.12/2000/4 (n 406) para 12.

⁴²⁰ *ibid.*

⁴²¹ *ibid.*

⁴²² *ibid.*

⁴²³ *Ibid.*, para 6-7.

⁴²⁴ *ibid.*, para 31.

⁴²⁵ *ibid.*, para 30.

1.3 Tripartite typology of obligations

As with all other human rights, the right to health imposes three types or levels of obligations: all States must respect, protect, and fulfill the right to health.⁴²⁶

The obligation to respect imposes on States to refrain from interfering directly or indirectly with the enjoyment of the right to health.⁴²⁷ Under the obligation to respect, States must not deny or limit equal access for all persons, for instance, to access healthcare services, from marketing unsafe drugs, etc.⁴²⁸ General Comment 14 also sets out the violations of the obligation to respect, including the actions, policies, or laws that can result in preventable mortality.⁴²⁹ It is also considered a violation of the obligation to respect the “suspension of legislation or the adoption of laws or policies that interfere with the enjoyment of any of the components of the right to health” and the failure of a State to consider the legal obligations through the right to health when entering into bilateral or multilateral agreements with other States, international organizations and other entities, such as multinational corporations.⁴³⁰ Thus, it can be interpreted that States not taking action on public health policies, including legislation, for NCD prevention is a violation of the right to respect, since most of the NCD deaths could be preventable. In addition, bilateral or multilateral agreements and trade agreements that facilitate the expansion of unhealthy commodities are in disagreement with the right to health.

The obligation to protect requires States to prevent third parties from interfering with the right to health.⁴³¹ It includes the duties of States to adopt legislation or to take other measures to ensure equal access to health care and health-related services provided by third parties. Under the violation of the obligation to protect, it is the failure of a State “to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties”.⁴³² This comprehends the omission to regulate the activities of corporations, including the failure to protect consumers from manufacturers of food.⁴³³ Moreover, the failure to discourage the production, marketing, and consumption of tobacco, narcotics, and other harmful substances is described as a violation of the obligation to protect.⁴³⁴

⁴²⁶ *ibid*, para 33.

⁴²⁷ *ibid*, para 34.

⁴²⁸ *ibid*.

⁴²⁹ *ibid*, para 50.

⁴³⁰ *ibid*.

⁴³¹ *ibid*, para 35.

⁴³² *ibid*, para 51.

⁴³³ *ibid*.

⁴³⁴ *ibid*.

Among the tripartite typology of obligations, the obligation to protect is the most relevant for this research. States must protect the right to health from private actors, and as described above, this includes food manufacturers. Thus, states must prevent food industries from promoting easy access to ultra-processed food and contributing to unhealthy diets that interfere with the right to health. Thus, a human rights approach addressing the commercial determinants of health is fundamental here.

Finally, the obligation to fulfill requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures to fully realize the right to health.⁴³⁵ Under the obligation to fulfill, States must facilitate, taking positive measures to ensure the enjoyment of the right to health. In addition, States must provide and promote the right to health. Among the violations of the obligation to fulfill is the failure to adopt or implement a national health policy designed to ensure the right to health for everyone.⁴³⁶ Again, there is a legal basis for States to adopt public health policies to tackle unhealthy diets.

Beyond the three types of obligations enunciated above, the Committee on Economic, Social, and Cultural Rights, in General Comment 3, has also confirmed that States' parties have minimum core obligations.⁴³⁷ In General Comment 14, the CESCR adopted an expansive list of the minimum core obligations for the right to health: non-discriminatory access to health facilities, goods, and services; access to the minimum, nutritionally adequate, and safe food; access to basic shelter, housing and sanitation, and safe and potable water; provision of essential drugs; equitable distribution of all health facilities, goods, and services; adoption and implementation of a national public health strategy and plan of action.⁴³⁸ It is imperative to highlight that the minimum core content includes that States must ensure access to nutritionally adequate and safe food. Once again, there is a provision related to the prevention of non-communicable diseases.

Moreover, the State's responsibility to protect, fulfill, and respect the right to health is unequivocal. However, due to their horizontal effect, international human rights obligations do not traditionally apply to private actors.⁴³⁹ Nevertheless, General Comment 14 affirms that all

⁴³⁵ *ibid*, para 33-36.

⁴³⁶ *ibid*, para 52.

⁴³⁷ UN Committee on Economic, Social and Cultural Rights, 'General Comment No. 3: The Nature of States Parties' Obligations (Art 2, para 1 of the Covenant)', (14 December 1990) UN Doc E/1991/23 para 10.

⁴³⁸ CESCR, '*General Comment No. 14*' UN Doc E/C.12/2000/4 (n 406) para 43.

⁴³⁹ See Part 4, Chapter 12, I, 4.1.

members of society, including the private business sector, have responsibilities regarding the realization of the right to health.⁴⁴⁰

Whereas the ICESCR is a legally binding instrument with States' parties accepting the responsibility to implement and maintain the rights in the convention, General Comment 14 is not binding on States' Parties. "General comments" or "general recommendations are interpretations of human rights treaties."⁴⁴¹ According to international law, general comments are considered "secondary soft law instruments," which means that they are sources of non-binding norms that interpret and add information to the rights and obligations contained in the respective human rights treaties.⁴⁴² In addition, general comments influence the interpretation of the state's obligations and have already been referred to by the International Court of Justice and domestic courts in the interpretation of international law.⁴⁴³ Although General comments are not binding, they reflect the experience with the particular provision and are a result of a debate among the members of supervisory bodies. Thus, they can be considered to have a certain degree of practical authority.⁴⁴⁴

2 Right to adequate food

2.1 Definition

The right to food is an underlying determinant of health, and General Comment 14 recognizes that "access to the minimum essential food which is nutritionally adequate and safe" is part of the minimum core obligations of States.⁴⁴⁵ Thus, the right to adequate food merits consideration.

Human rights are interdependent and also related. The right to adequate food is also a fundamental right recognized in Art. 25 of the Universal Declaration of Human Rights⁴⁴⁶ and

⁴⁴⁰ CESCR, 'General Comment No. 14' UN Doc E/C.12/2000/4 (n 406) para 42.

⁴⁴¹ Office of the United Nations High Commissioner for Human Rights, 'Treaty Bodies, General Comments' <<https://www.ohchr.org/en/treaty-bodies/general-comments>> accessed 9 April 2023.

⁴⁴² Helen Keller and Leena Grover, '4 - General Comments of the Human Rights Committee and Their Legitimacy' in Helen Keller and Geir Ulfstein (eds), *UN Human Rights Treaty Bodies: Law and Legitimacy* (Cambridge University Press 2012).

⁴⁴³ Fiona H McKay and Ann Taket, *Health Equity, Social Justice and Human Rights: Global and European Perspectives* (Routledge 2020) 98.

⁴⁴⁴ Nicola Jägers, *Corporate Human Rights Obligations: In Search of Accountability* (Intersentia 2002) 45.

⁴⁴⁵ CESCR, 'General Comment No. 14' UN Doc E/C.12/2000/4 (n 406) para 43.

⁴⁴⁶ UNGA, *Universal Declaration of Human Rights 1948* (n 396) art 25.

Art. 11 of the ICESCR.⁴⁴⁷ CESCR General Comment No. 12 presents the core elements of the right to food, which must be realized progressively.⁴⁴⁸ In addition, as with all human rights, States carry legal obligations to the realization of the right to adequate food. For instance, “Every State is obliged to ensure for everyone under its jurisdiction access to the minimum essential food which is sufficient, nutritionally adequate and safe, to ensure their freedom from hunger”.⁴⁴⁹

Furthermore, food must be available, accessible, and adequate. There is a lot of discussion about the definition of what constitutes nutritionally adequate food. This research will not explore this debate in detail. Hence, it will use the definition of adequacy established by the Committee on Economic, Social, and Cultural Rights, in which adequacy means that the food must satisfy dietary needs, taking into account the individual’s age, living conditions, health, occupation, sex, etc.⁴⁵⁰ Moreover, General Comment 12 emphasizes that “right to adequate food shall therefore not be interpreted in a narrow or restrictive sense which equates it with a minimum package of calories, proteins, and other specific nutrients”.⁴⁵¹ In this context, the Office of the United Nations High Commissioner for Human Rights observed that food that is energy-dense, low-nutrient, and can contribute to obesity and other illnesses, is an example of inadequate food.⁴⁵²

2.2 Tripartite typology of obligations

Moreover, the three types of obligations on States parties are also imposed by the right to adequate food. Thus, States must respect, protect, and fulfill access to adequate food.⁴⁵³ Violation of the right to food occurs through the direct action of States or other entities insufficiently regulated by States, for instance, failure to regulate activities of individuals or groups so as to prevent them from violating the right to food of others, or the failure of a State

⁴⁴⁷ The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions. The States Parties will take appropriate steps to ensure the realization of this right, recognizing to this effect the essential importance of international co-operation based on free consent. United Nations (General Assembly). UN General Assembly, *International Covenant on Economic, Social and Cultural Rights* (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3 art 11.

⁴⁴⁸ UN Committee on Economic, Social and Cultural Rights, ‘General Comment No. 12: The Right to Adequate Food (Art 11 of the Covenant)’ (12 May 1999) UN Doc E/C.12/1999/5.

⁴⁴⁹ *ibid*, para 14.

⁴⁵⁰ *ibid*, para 7.

⁴⁵¹ *ibid*, para 6.

⁴⁵² Office of the United Nations High Commissioner for Human Rights, *Fact Sheet No 34: The Right to Adequate Food* (April 2010) <<https://www.refworld.org/docid/4ca460b02.html>> accessed 7 July 2025.

⁴⁵³ CESCR, ‘General Comment No. 12’ UN Doc E/C.12/1999/5 (n 448) para 15.

to take into account its international legal obligations regarding the right to food when entering into agreements with other States or with international organizations.⁴⁵⁴ The CESCR General Comment No. 12 highlights that even though at a first glance, only States can be held accountable for the violation of human rights, the private business sector also has responsibilities in the realization of the right to adequate food. They should pursue their activities within the framework of a code of conduct conducive to the respect of the right to adequate food.⁴⁵⁵ In addition, States should provide an environment that facilitates the implementation of these responsibilities and should take appropriate steps to ensure that activities of the private business sector and civil society are in conformity with the right to food.⁴⁵⁶

Taking into consideration the context of unhealthy diets and the facilitated access and availability of ultra-processed foods and sweetened beverages, it is possible to assert that there is a violation of the right to nutritious, adequate food, and consequently, there is a violation of the right to health. In 2020, almost 3.1 billion people could not afford a healthy diet, and according to the WHO Director-General, Tedros Adhanom Ghebreyesus, every year, 11 million people die due to unhealthy diets.⁴⁵⁷ Accessible, nutritious, and affordable food is one of the most fundamental ways to improve public health. Therefore, a human-rights-based approach to the right to health englobes the underlying determinants of health and is a possible path to non-communicable disease prevention.

For instance, the Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Unhealthy foods, non-communicable diseases, and the right to health (A/HRC/26/31) draws the line that access to nutritiously safe food is intrinsic to the fulfillment of the highest attainable standard of health.⁴⁵⁸ Moreover, it states that food security and nutrition security are connected to the right to health. The FAO defines food security as “all people, at all times, have physical and economic access to sufficient, safe and nutritious food necessary to meet their dietary needs and food preferences for an active and healthy life”.⁴⁵⁹

⁴⁵⁴ *ibid*, para 19.

⁴⁵⁵ *ibid*, para 20.

⁴⁵⁶ *ibid*, para 27.

⁴⁵⁷ World Health Organization, ‘UN Report: Global Hunger Numbers Rose to as Many as 828 Million in 2021’ (*WHO* 2022) <<https://www.who.int/news/item/06-07-2022-un-report--global-hunger-numbers-rose-to-as-many-as-828-million-in-2021>> accessed 9 April 2023.

⁴⁵⁸ UNGA, ‘Report of the Special Rapporteur on the Right of Everyone to the Enjoyment’ (n 409).

⁴⁵⁹ Food and Agriculture Organization of the United Nations, Report of the World Food Summit, 13-17 November 1996 (FAO 1996) para 1.

The Report explores the impacts of globalization on food systems and the impacts of the promotion and marketing of unhealthy foods on the increase in the consumption of unhealthy foods, which have been linked to diet-related NCDs.⁴⁶⁰ In addition, it highlights that under the right-to-health framework, States have a core and non-derogable obligation to ensure access to the minimum essential food that is nutritionally adequate to ensure freedom from hunger for everyone. It emphasizes that under the tripartite levels of obligations to respect, protect, and fulfill, States should not only provide nutritious food but also institute measures in all areas of policymaking to reduce the burden of diet-related NCDs.⁴⁶¹

Moreover, the Report presents four different areas in which States should act in order to tackle NCDs: information and awareness-raising (calling for the use of nutrition prolling and Education and public awareness programs); fiscal policies (suggesting that agricultural subsidies benefiting unhealthy foods could be removed and shifted to subsidies for increasing the production of healthier foods); policies on marketing and promotion of unhealthy foods (particularly to formulate laws and a regulatory framework focused in reducing children’s exposure to powerful food and drink marketing); and policies on foreign direct investments.

Finally, the Report highlights the urgent need for States to address structural changes in the food environment, which negatively impact individuals’ enjoyment of the right to adequate and nutritious food, an underlying determinant of the right to health.

2.3 International institutions and the right to adequate food

The WHO Constitution establishes that to achieve its objective, the Organization shall “promote, in cooperation with other specialized agencies where necessary, the improvement of nutrition...”⁴⁶² and “establish and promote international standards with respect to food...”⁴⁶³ Therefore, the WHO mandate includes significant provisions linked to the right to adequate food.

Beyond the WHO and the WTO, other UN health-related agencies are relevant to this research. For instance, the FAO is a specialized agency of the United Nations focused on the eradication

⁴⁶⁰ UNGA, ‘Report of the Special Rapporteur on the Right of Everyone to the Enjoyment’ (n 409).

⁴⁶¹ *ibid.*

⁴⁶² WHO, *Constitution of the World Health Organization* (n 383) art 2(i).

⁴⁶³ *ibid.*

of hunger, food insecurity, and malnutrition.⁴⁶⁴ Unlike the WHO, the FAO does not have international law-making powers, but established the Codex Alimentarius, a collection of international food standards, codes of practice, guidelines, and recommendations to protect the consumers' health and ensure fair practices in the food trade.⁴⁶⁵ The Global Strategy on Diet, Physical Activity and Health explicitly mentions the Codex Alimentarius, stating that international norms and standards, particularly those drawn up by the Codex Commission, may strengthen public health efforts.⁴⁶⁶

Finally, in the Report submitted by the Special Rapporteur on the right to food in 2011, SCHUTTER highlighted that “in accordance with their obligation to respect, protect and fulfil the right to adequate food” States should adopt a national strategy for the realization of the right to adequate food which integrates the objective of guaranteeing the right to adequate diets for all and sets specific targets and time frames for action; adopt statutory regulation on the marketing of food products, as the most effective way to reduce marketing of foods high in fats, sodium or sugar (HFSS foods) to children, as recommended by WHO, and restrict marketing of these foods to other groups; impose taxes on soft drinks, and on HFSS foods, in order to subsidize access to fruits and vegetables and educational campaigns on healthy diets.⁴⁶⁷

IV Interconnecting regimes that have an impact on human rights: trade law and the right to health

1 International trade law and public health

As GOSTIN introduces, the third main source for global health law would be the interconnecting legal regimes that impact health. International trade law has directly impacted public health measures spanning from tobacco control to the regulation of food products. One of the objectives described in the Preamble of the WTO Agreement is to “raise standards of living,”

⁴⁶⁴ Food and Agriculture Organization of the United Nations, ‘About FAO’ (FAO) <<https://www.fao.org/about/en>> accessed 6 April 2023.

⁴⁶⁵ Brigit Toebes and others, *Health and Human Rights: Global and European Perspectives* (2nd edn., Intersentia 2022) 112.

⁴⁶⁶ World Health Organization, *Global Strategy on Diet, Physical Activity and Health* (WHO 2004) para 59.

⁴⁶⁷ UN General Assembly, ‘Report / submitted by the Special Rapporteur on the Right to Food, Olivier de Schutter’ (26 December 2011) UN Doc A/HRC/19/59 para 51(a)-(d).

which can be interpreted as rights-based societal.⁴⁶⁸ Moreover, all WTO member states have ratified at least one international or regional human rights instrument that codifies the right to health and therefore comply with the tripartite levels of obligation.⁴⁶⁹

International trade law is intrinsic to the realization of the right to health in the context of NCD prevention. However, trade arguments have frequently been invoked to contest or delay the implementation of public health regulations aimed at curbing NCDs at the international level but also in the national level.⁴⁷⁰ This tension underscores the complex interplay between economic governance and health protection, raising critical questions about how to reconcile trade commitments with states' human rights obligations.

In 1994, the Marrakesh Agreement established the creation of the WTO which has as its objectives, inter alia, raising standards of living, expanding the production of and trade in goods and services, while allowing for the optimal use of the world's resources for objective of sustainable development and ensuring that developing countries secure a share in the growth in international trade commensurate and their economic development.⁴⁷¹ The WTO is a global international organization that deals with the rules of trade between nations.⁴⁷² One of its main approaches is trade liberalization to promote economic growth and development, which directly impacts public health.

Trade liberalization allowed the expansion of ultra-processed foods and western diets worldwide, promoting a “nutrition transition” that has significantly influenced the rise in obesity and NCD-related diseases.⁴⁷³ Thus, it can be asserted that the WTO agreements directly and indirectly impact public health. The direct effect would be the limitations these agreements put on public health policy options at a national level. In contrast, the indirect effect would be seen in income generation and distribution, and its consequences to the economy and development.⁴⁷⁴

⁴⁶⁸ Chuang-Feng Wu and Chien-Huei Wu, 'Chapter 16: International Trade, Public Health, and Human Rights' in Lawrence O Gostin and Benjamin Mason Meier (eds), *Foundations of Global Health & Human Rights* (Oxford University Press 2020) 356.

⁴⁶⁹ *ibid.*

⁴⁷⁰ Anne Marie Thow, 'Protecting Noncommunicable Disease Prevention Policy in Trade and Investment Agreements' (2022) 100 *Bulletin of the World Health Organization* 268.

⁴⁷¹ Marrakesh Agreement Establishing the World Trade Organization (adopted 15 April 1994, entered into force 1 January 1995) 1867 UNTS 154 preamble.

⁴⁷² World Trade Organization, 'What Is the WTO?' (*WTO*) <https://www.wto.org/english/thewto_e/whatis_e/whatis_e.htm> accessed 6 April 2023.

⁴⁷³ See Part 1, Chapter 2, I, 2 Globalization and trade law and 3 Nutrition transition to unhealthy diets.

⁴⁷⁴ Carlos M Correa, 'Implementing National Public Health Policies in the Framework of WTO Agreements' (2000) 34 *Journal of World Trade*.

In 2006, the WHA passed resolution 59.26 recognizing “the demand for information on the possible implications of international trade and trade agreements for health and health policy at national, regional, and global levels”.⁴⁷⁵ It also stressed the need for better coordination between international trade and health.⁴⁷⁶ Moreover, in 2007 it was issued the Oslo Ministerial Declaration by the foreign ministers of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand which affirmed the “interconnectedness of trade, health, and development, including trade and health policies in the formulation of all bilateral, regional, and multilateral trade agreements”.⁴⁷⁷

2 The legal framework for health measures under WTO agreements

Within the principles of the trading system, the principle of non-discrimination and necessity requirements are highly relevant to the balance between health and trade. International trade law recognizes the protection of human health as a legitimate objective to justify exceptions to trade liberalization. In particular, Art. 2.2 of the Agreement on Technical Barriers to Trade (TBT) stipulates that “technical regulations shall not be more trade-restrictive than necessary to fulfill a legitimate objective, including ... the protection of human health and safety”.⁴⁷⁸ Furthermore, the preamble of the TBT recognizes that “no country should be prevented from taking measures necessary to ensure the quality of its exports, or for the protection of human, animal or plant life or health”.⁴⁷⁹

Moreover, under the general exceptions of the General Agreement on Tariffs and Trade (GATT), Art. XX(b) establishes that WTO Members may adopt measures that violate GATT if it is necessary to protect human health, under the requirement that such measures are not applied in a manner which would constitute a means of arbitrary or unjustifiable discrimination between countries where the same conditions prevail, or a disguised restriction on international trade.⁴⁸⁰ It is possible to observe that the GATT and the TBT have provisions related to the two supra-cited principles.

⁴⁷⁵ World Health Assembly, ‘International Trade and Health’ WHA Res 59.26 (27 May 2006).

⁴⁷⁶ *ibid.*

⁴⁷⁷ Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand, ‘Oslo Ministerial Declaration—Global Health: A Pressing Foreign Policy Issue of Our Time’ (2007) 369 *The Lancet* 1373.

⁴⁷⁸ WTO Agreement on Technical Barriers to Trade (1 January 1995) 1868 UNTS 120 (TBT).

⁴⁷⁹ *ibid.*

⁴⁸⁰ General Agreement on Tariffs and Trade (adopted 30 October 1947, entered into force provisionally 1 January 1948) 55 UNTS 194; Marrakesh Agreement Establishing the World Trade Organization (n 471).

However, as MCGRADY describes, the balance between the right to regulate and WTO obligations is an area still in development.⁴⁸¹ For instance, there is no fixed methodology to determine the trade restrictiveness of a measure or even the contribution to achieving the “legitimate objective” here, human health.⁴⁸² Nevertheless, health objectives have been recognized in disputes under the GATT as vital and important to the highest degree.⁴⁸³ For instance, in the case of Brazil-Tires, the Appellate Body affirmed that “few interests are more vital and important than protecting human beings from health risks”.⁴⁸⁴

Another trade agreement that merits consideration is the Application of Sanitary and Phytosanitary Measures (SPS Agreement). The SPS Agreement aims to establish a multilateral framework of rules and disciplines to guide the development, adoption, and enforcement of sanitary and phytosanitary measures in order to minimize their negative effects on trade.⁴⁸⁵ It is understood as a sanitary or phytosanitary measure, which “protects human or animal life or health within the Member’s territory from risks arising from additives, contaminants, toxins or disease-causing organisms in foods, beverages or feedstuffs”.⁴⁸⁶ MCGRADY notes that the SPS is perceived as an agreement that addresses food-safety measures and measures intended to prevent the spread of pests or diseases, and that at the time of its negotiation, it was not thought to be used in the context of nutritional qualities of foods.⁴⁸⁷

However, recently, there have been interpretations that measures related to foods' nutritional qualities are not that different from food safety measures. BROAD interprets food safety through a more comprehensive lens, which includes not just acute, ingestion-related risks (such as foodborne illness) but also whole-diet cumulative ingestion risks and cradle-to-grave risks of food production and disposal.⁴⁸⁸

In addition, exploring the path of food additives, ultra-processed foods, which constitute a significant part of unhealthy diets, have, in most cases, additives in their composition that have

⁴⁸¹ Benn McGrady, ‘Chapter 5: Health and International Trade Law’ in Gian Luca Burci and Brigit Toebes (eds), *Research Handbook on Global Health Law: Research Handbooks on Globalisation and the Law Series* (Edward Elgar Publishing 2018) 106-107.

⁴⁸² *ibid.*, 114.

⁴⁸³ *ibid.*

⁴⁸⁴ Appellate Body Report, *Brazil – Measures Affecting Imports of Retreaded Tyres* WT/DS332/AB/R (adopted 3 December 2007).

⁴⁸⁵ WTO Agreement on the Application of Sanitary and Phytosanitary Measures (15 April 1994) 1867 UNTS 493 (SPS).

⁴⁸⁶ *ibid.*, Annex A 1(b).

⁴⁸⁷ Benn McGrady, *Trade and Public Health – the WTO, Tobacco, Alcohol and Diet* (Cambridge University Press 2011) 340 175.

⁴⁸⁸ Emily M Broad and Margot J Pollans, ‘The New Food Safety’ (2019) 107 *California Law Review* 1173 <<https://www.jstor.org/stable/26850863>> accessed 27 January 2025.

been linked to health problems.⁴⁸⁹ Thus, ultra-processed food can be interpreted through the lens of food safety, which would be under the SPS Agreement.

Moreover, it can be argued that saturated fats, sugars, or salt have characteristics analogous to toxins.⁴⁹⁰ Thus, if we understand that artificial trans-fat constitutes an additive,⁴⁹¹ it would fall under the definitions of Annex A 1. (b) SPS Agreement, and a measure restricting or prohibiting artificial trans-fat in food would be an SPS measure to protect human health.⁴⁹² Moreover, in conformity with Art. XX (b) of the GATT, Art. 2 of the SPS Agreement establishes that the sanitary or phytosanitary measure is only applied under the necessity requirement.⁴⁹³ In addition, the measures must not arbitrarily or unjustifiably discriminate between Members.⁴⁹⁴

It is imperative to highlight that, beyond the WTO's trade enforcement, there are bilateral/multilateral free trade agreements (FTA) that add additional requirements to eliminate most states' regulations of international trade.⁴⁹⁵ These FTAs can negatively impact public health, for example, the effects of NAFTA on Mexico's high rates of obesity.⁴⁹⁶

3 Intellectual property and public health legal tools

Tobacco

Another aspect of trade law related to public health is intellectual property (IP) rights. For instance, the implementation of plain packaging for tobacco products has sparked significant debate over the conflict between public health protection measures and IP protections.⁴⁹⁷ A landmark example is the plain packaging WTO disputes against Australia concerning multiple

⁴⁸⁹ Melissa M Lane and others, 'Ultra-Processed Food Exposure and Adverse Health Outcomes: Umbrella Review of Epidemiological Meta-Analyses' (2024) 384 BMJ; Laury Sellem and others, 'Food Additive Emulsifiers and Risk of Cardiovascular Disease in the NutriNet-Santé Cohort: Prospective Cohort Study' (2023) 382 BMJ.

⁴⁹⁰ McGrady, *Trade and Public Health – the WTO, Tobacco, Alcohol and Diet* (n 487) 178-179.

⁴⁹¹ *ibid*, "substance added to another to give it specific qualities" or "any substance not normally consumed as a food by itself and not normally used as a typical ingredient of the food".

⁴⁹² *ibid*, 180.

⁴⁹³ WTO SPS (n 485) art 2.2.

⁴⁹⁴ *ibid*, art 2.3.

⁴⁹⁵ Wu and Wu, 'Chapter 16: International Trade, Public Health, and Human Rights' (n 468) 366.

⁴⁹⁶ See Part 1, Chapter 2, 3 Nutrition transition to unhealthy diets.

⁴⁹⁷ Alberto Alemanno and Enrico Bonadio, *The New Intellectual Property of Health: Beyond Plain Packaging* (Edward Elgar Publishing 2016) 1-12.

contraventions of the TRIPS (Trade-Related Aspects of Intellectual Property Rights) agreement.⁴⁹⁸

Australia was the first country to adopt standardized or plain packaging laws for tobacco products in 2011.⁴⁹⁹ In response, several WTO members, Honduras, the Dominican Republic, Indonesia, and Cuba, initiated proceedings against Australia, alleging that the measure was inconsistent with its obligations under the TRIPS, the TBT Agreement, and the GATT.⁵⁰⁰ A WTO Panel was established in 2014 to consider all four disputes.

On 28 June 2018, the Panel issued a consolidated report dismissing the complainants' claims. Honduras and the Dominican Republic subsequently appealed the Panel's findings to the WTO Appellate Body, limiting their appeals to specific provisions (Art. 2.2 of the TBT Agreement and Art. 16.1 and 20 of the TRIPS Agreement). In its final ruling, circulated on 9 June 2020, the Appellate Body upheld the Panel's conclusions.⁵⁰¹

The Appellate Body confirmed that Australia's tobacco plain packaging measures were not more trade-restrictive than necessary to achieve the legitimate objective of protecting public health. The ruling clarified that trademark owners do not have a positive right to use their trademarks under WTO TRIPS agreement, but only the right to prevent third parties from using them. Accordingly, the restrictions imposed by Australia's plain packaging laws were found to be a justified restriction on the use of trademarks and did not amount to a violation of IP protections under WTO law.⁵⁰²

The legal battles surrounding Australia's plain packaging law serve key development in the interpretation of the relationship between public health objectives and international intellectual property. It affirms that states retain a degree of regulatory autonomy to implement measures aimed at protecting public health, even where such measures may limit the commercial use of intellectual property.

⁴⁹⁸ Mark Davison, 'Chapter 6: Plain Packaging of Tobacco Products and the WTO Challenge' in Alberto Alemanno and Enrico Bonadio (eds), *The New Intellectual Property of Health: beyond Plain Packaging* (Edward Elgar Publishing 2016).

⁴⁹⁹ *ibid.*

⁵⁰⁰ Andrew D Mitchell and Theo Samlidis, 'The Implications of the WTO Tobacco Plain Packaging Disputes for Public Health Measures' [2021] *International & Comparative Law Quarterly*.

⁵⁰¹ *ibid.*

⁵⁰² World Trade Organization, *Australia – Certain Measures Concerning Trademarks, Geographical Indications and Other Plain Packaging Requirements Applicable to Tobacco Products and Packaging*, Appellate Body Reports WT/DS435/AB/R and WT/DS441/AB/R (9 June 2020).

Front-of-package labeling

Recently, similar tensions between IP rights and public health have emerged with the introduction of front-of-package (FOP) labeling aimed at reducing the consumption of unhealthy food products.⁵⁰³ One notable case is Chile's prohibition on using children's cartoon characters on products with the warning label "high in" energy, sugar, fats, or salt. Food companies argued that this restriction infringed upon their IP rights, specifically their trademarks.⁵⁰⁴ Chilean courts ruled in favor of the public health measure, emphasizing that trademarks fall within the scope of the country's Food Act and related regulations. Consequently, the restriction on their use was not considered an unlawful deprivation of property. The Court further underscored the balance between property rights and the right to health, concluding that Chile's advertising limitations were justified on public health grounds.⁵⁰⁵

At the international level, transnational food and beverage companies such as Nestlé, Kellogg's, and Coca-Cola, through their trade associations, have raised concerns before the WTO's Technical Barriers to Trade Committee regarding the adoption of front-of-package labeling regulations in countries like Chile, Peru, Indonesia, Ecuador, Uruguay, and Mexico.⁵⁰⁶ These companies argue that such measures create unnecessary obstacles to trade, allegedly violating Art. 2.2 and 2.4 of the TBT Agreement.⁵⁰⁷ In the case of Mexico, various WTO members, including Canada, Colombia, Costa Rica, El Salvador, the European Union, Guatemala, Paraguay, Switzerland, and the United States, have submitted comments to the TBT Committee in response to Mexico's proposed front-of-package label (FOPL).⁵⁰⁸ It is important to underscore, however, that despite these expressions of concern, no formal legal challenges or litigation have been initiated at the WTO level regarding FOP labeling.

⁵⁰³ Ignacio Carreño and Tobias Dolle, 'The Relationship between Public Health and IP Rights: Chile Prosecutes Kellogg's, Nestlé and Masterfoods for Using Cartoons Aimed at Attracting Children' (2017) 8 *European Journal of Risk Regulation* 170.

⁵⁰⁴ Marcelo Campbell, 'Chile: Front-of-Package Warning Labels and Food Marketing' (2022) 50 *Journal of Law, Medicine & Ethics* 298.

⁵⁰⁵ *ibid.*

⁵⁰⁶ Eric Crosbie, Angela Carriedo and Laura Schmidt, 'Hollow Threats: Transnational Food and Beverage Companies' Use of International Agreements to Fight Front-of-Pack Nutrition Labeling in Mexico and Beyond' (2020) 11 *International Journal of Health Policy and Management*.

⁵⁰⁷ *ibid.*

⁵⁰⁸ The Global Health Advocacy Incubator, 'Front of Package Labeling – Preparing for and Responding to International Trade Law Arguments' (*Advocacy Incubator* 2024) <<https://www.advocacyincubator.org/program-areas/food-and-nutrition/reducing-demand-for-unhealthy-food/resources>> accessed 2 April 2025.

CHAPTER 5: INTERNATIONAL FRAMEWORK

I Preliminary remarks

This chapter examines the international legal framework for NCD prevention. It will map the range of legal instruments, binding and non-binding, that address the growing burden of NCDs. By analyzing these instruments at the international level, the chapter aims to elucidate how they contribute not only to the regulation of NCD risk factors but also to the emergence of public-private partnerships as alternative tools to traditional command-and-control regulations. A key dimension of this analysis concerns the role of private actors in global health governance and how their participation is framed, encouraged, or limited by the existing international legal instruments.

II The rise of non-communicable diseases in the global health agenda

At the international level, the NCDs first gained attention in May 1951 when, in the first session of the Consultative Committee for Europe hosted by the WHO European Regional Office, there were recommendations for specific WHO programs focused on non-infectious chronic diseases of adult populations, dental hygiene, and nutrition.⁵⁰⁹ In 1957, after the Symposium on the Public Health Aspects of Chronic Disease in the Netherlands, a report was published recognizing that the “degenerative diseases” (CVD, diabetes, respiratory illnesses, and cancer) were related to certain risks, behaviors, and modes of life.⁵¹⁰

In 1972, the North Karelia Project was launched to tackle the high CVD mortality in Finland.⁵¹¹ The project goal was to develop community-based interventions to reduce the prevalence of lifestyle-modifiable risk factors within populations.⁵¹² Following the achievements of this initiative, the WHO developed different programs in the early 1980s (first focusing on CVD) with the aim of strengthening its NCD programming.⁵¹³

In 2000, the WHO, for the first time, identified a global threat from the mortality of non-communicable diseases and the need for action. As a result, the “Global strategy for the

⁵⁰⁹ Leah N Schwartz, Jonathan D Shaffer and Gene Bukhman, ‘The Origins of the 4×4 Framework for Noncommunicable Disease at the World Health Organization’ (2021) 13 SSM - Population Health 100731.

⁵¹⁰ *ibid.*

⁵¹¹ *ibid.*

⁵¹² *ibid.*

⁵¹³ *ibid.*

prevention and control of noncommunicable diseases” was adopted.⁵¹⁴ This document acknowledges the impact of globalization and the rising gap between high-income and low- and middle-income countries. The Global Strategy aimed to support the Member States in preventing and reducing the risk factors, monitoring NCDs and risk factors, and strengthening the health system response in the treatment of people with NCDs and the risk factors.⁵¹⁵

In 2014, LIBERMAN underscored that, “after being neglected as a global health, economic and political priority, the case for attention and action on NCDs has become irresistible.”⁵¹⁶ While NCDs have been recognized as a pressing issue on the international agenda for nearly two decades, progress in prevention, aside from tobacco control, has been limited.

III International law sources

The international legal framework for the prevention of non-communicable diseases operates through a combination of hard law and soft law instruments.⁵¹⁷ Thus, it is crucial to explore in further detail the differences between binding and non-binding instruments; for this, a more detailed explanation of international law sources will be explored next.

According to Art. 38 of the Statute of the International Court of Justice, the sources in international law are treaties and conventions, international custom, general principles of law, and the “subsidiary sources” of judicial decisions and legal teachings.⁵¹⁸ Under the scope of Art. 38, treaties and customary international law are considered the principal sources of international law.

Art. 2 of the Vienna Convention on the Law of Treaties defines a treaty as “an international agreement concluded between States in written form and governed by international law, whether embodied in a single instrument or in two or more related instruments and whatever its particular designation;”.⁵¹⁹ In addition, Art. 26 enunciates the binding nature of the treaties

⁵¹⁴ World Health Organization, ‘Global strategy for the prevention and control of noncommunicable diseases’ WHO Doc A53/14 (22 March 2000).

⁵¹⁵ *ibid.*

⁵¹⁶ Liberman, ‘Making Effective Use of Law in the Global Governance of NCD Prevention’ (n 390).

⁵¹⁷ It is imperative to make a remark that there has been considerable progress considering NCDs prevention and children. Nonetheless, the focus of this research is the population as a whole, therefore, this thesis, will not analyze in detail the instruments dedicated exclusively to children, but rather make allusion when relevant.

⁵¹⁸ Statute of the International Court of Justice (adopted 26 June 1945, entered into force 24 October 1945) 33 UNTS 993 art 38.

⁵¹⁹ Vienna Convention on the Law of Treaties (adopted 23 May 1969, entered into force 27 January 1980) 1155 UNTS 331.

through the principle of the *pacta sunt servanda*, which means that every treaty in force is binding upon the parties to it.⁵²⁰

Legal norms are not binary but rather based on graduated normativity, from binding to nonbinding. In global health law, this normativity goes from binding treaties and norms (for instance, the norms encompassed in the right to health and other human rights norms codified under international law) to authoritative nonbinding normative instruments, such as resolutions, declarations, guidelines, protocols, and recommendations.⁵²¹

Here, it is essential to make a parenthesis about hard law and soft law. ABBOTT has defined hard law as “legally binding obligations that are precise (or can be made precise through adjudication or the issuance of detailed regulations) and that delegate authority for interpreting and implementing the law”.⁵²² Moreover, CRAWFORD defines hard law as “an obligation of a state or states for the breach of which it or they are responsible, whatever form of sanction or penalty that responsibility may entail.”⁵²³ Thus, hard law is derived from its source, for instance, treaties and customs as mentioned above.

The advantages attributed to hard law are mainly the strong powers of enforceability, as it can enable enforcement against non-state actors and may reduce transnational costs.⁵²⁴ However, hard law has high sovereignty costs on countries, high contracting costs, and the sanctions are not seen as an effective form of enforcement due to the abuse of sanctions.⁵²⁵

On the other hand, BOYLE defines soft law as a variety of non-legally binding instruments used in contemporary international relations by States and international organizations.⁵²⁶ Additionally, soft law has been described as “those international norms, principles, and procedures . . . outside the system of formal sources of Art. 38, paragraph 1 of the ICJ Statute . . . [that lack] the requisite normative content to create enforceable rights and obligations”.⁵²⁷

⁵²⁰ *ibid*, art 26.

⁵²¹ Sharifah Sekalala and Haleema Masud, ‘Soft Law Possibilities in Global Health Law’ (2021) 49 *Journal of Law, Medicine & Ethics* 152.

⁵²² Kenneth W Abbott and Duncan Snidal, ‘Hard and Soft Law in International Governance’ (2000) 54 *International Organization* 421.

⁵²³ Cynthia Crawford Lichtenstein, ‘Hard Law v. Soft Law: Unnecessary Dichotomy?’ (2001) 35 *The International Lawyer* 1433 <<http://www.jstor.org/stable/40707627>> accessed 8 April 2023.

⁵²⁴ Sharifah Sekalala, *Soft Law and Global Health Problems - Lessons from Responses to Hiv/Aids, M.* (Cambridge University Press 2017) 40-44.

⁵²⁵ *ibid*, 44-50.

⁵²⁶ Alan Boyle, ‘Soft Law in International Law-Making’ in Malcolm Evans (ed), *International Law* (5th edn, Oxford University Press 2018) 119.

⁵²⁷ Elizabeth Crawford, ‘What Is “Soft” Law? An Analysis of the Concept of Non-Binding Instruments and Provisions in International Law’, *Non-Binding Norms in International Humanitarian Law: Efficacy, Legitimacy, and Legality* (Oxford University Press 2021).

Another definition for soft law is “rules of conduct which, in principle, have no legally binding force but which nevertheless may have practical effects”.⁵²⁸ Therefore, the commonly accepted definition focuses on the lack of a formal binding effect of a norm. Examples of soft law include recommendations, guidelines, codes of conduct, non-binding resolutions, and standards.

ABBOTT and SNIDAL explain soft law through a spectrum of three component elements: obligation, precision, and delegation.⁵²⁹ Obligation means the state’s duty to rule or commitment, or a set of rules or commitments. Precision is the way the law is written to an extent, with details and precise language. Delegation implies that third parties have been granted authority to implement, interpret, and apply the rules.⁵³⁰ Thus, under their understanding, “soft law” begins once legal arrangements are weakened along one or more of the dimensions of obligation, precision, and delegation.⁵³¹

Soft law is easier to negotiate than international treaties, since it uses fewer resources and can be negotiated more quickly.⁵³² In addition, because of the non-binding nature, it is easier to achieve a consensus between countries with different interests, as well as with the commercial interests of private actors.⁵³³ On the other hand, the main critiques regarding soft law are their vague normative content, lack of legitimacy, and potential threat to weakening international law.⁵³⁴

Finally, there is a complementarity between soft and hard norms. Soft law can be seen as a way to achieve hard law (a precursor to a treaty) and can also help interpret hard law rules.⁵³⁵

Most of the resolutions adopted by the WHO in the context of NCD prevention are non-binding.⁵³⁶ This puts into debate the effectiveness of these measures and the normative power exercised by the WHO. However, there are a few explanations for the use of soft norms in global health law. First, global health issues are highly complex and interdependent with other international law regimes, for instance, trade.⁵³⁷ Moreover, non-state actors, such as corporations, which are outside of the direct scope of WHO governance, have a significant role

⁵²⁸ *ibid.*

⁵²⁹ Kenneth W Abbott and others, ‘The Concept of Legalization’ (2000) 54 *International Organization* 401.

⁵³⁰ *ibid.*

⁵³¹ Abbott and Snidal, ‘Hard and Soft Law in International Governance’ (n 522).

⁵³² Gostin, *Global Health Law* (n 3) 66.

⁵³³ Sekalala and Masud, ‘Soft Law Possibilities in Global Health Law’ (n 521).

⁵³⁴ *ibid.*, 63-68.

⁵³⁵ Wu and Wu, ‘Chapter 16: International Trade, Public Health, and Human Rights’ (n 468) 524.

⁵³⁶ Part 2, Chapter 5, V.

⁵³⁷ Chapter 4, IV.

in the context of NCDs.⁵³⁸ Finally, as in the case of FCTC, it is not easy for the WHO to advance state implementation.⁵³⁹

IV Binding instruments: WHO Framework Convention on Tobacco Control

1 Preliminary remarks

This focuses primarily on the risk factor of unhealthy diets. However, it is imperative to briefly explore some key aspects of the only binding instrument adopted in the context of NCDs, which is the WHO Framework Convention on Tobacco Control.

In 1996, the WHA requested the Director-General to initiate the development of a framework convention on tobacco control.⁵⁴⁰ Then, in 2003, the WHO Framework Convention on Tobacco Control was adopted, which is considered a landmark in global health law since it was the first time the WHA used its normative power to adopt a legally binding treaty. The FCTC entered into force in 2005, and 90 days after it had been acceded to, ratified, accepted, or approved by 40 States.⁵⁴¹ According to the WHO, nowadays, there are 182 Parties to the Convention.⁵⁴²

The FCTC depends on its ratification. It is imperative to highlight that Switzerland signed the WHO Framework Convention on Tobacco Control in 2004 but has not ratified it.⁵⁴³ The tobacco industry's lobbying impact on Swiss policy is vast since the headquarters of Philip Morris, British American Tobacco, and Japan Tobacco International are based in the country. In addition, countries such as the United States, Argentina, Malawi, and Cuba, which are mainly tobacco-growing states, also never ratified the FCTC.⁵⁴⁴

The preamble of FCT reaffirms the right of all people to the highest standard of health and establishes as a priority the State's responsibility to protect public health.⁵⁴⁵ General Comment

⁵³⁸ Sekalala and Masud, 'Soft Law Possibilities in Global Health Law' (n 521).

⁵³⁹ *ibid.*

⁵⁴⁰ WHO Framework Convention on Tobacco Control (n 31).

⁵⁴¹ *ibid.*, art 3.

⁵⁴² *ibid.*

⁵⁴³ Framework Convention Alliance, 'Parties to the WHO FCTC (ratifications and accessions)' (*FCTC* 2017) <<https://fctc.org/parties-ratifications-and-accessions-latest/>> accessed 06 April 2023.

⁵⁴⁴ *ibid.*

⁵⁴⁵ WHO Framework Convention on Tobacco Control (n 31) preamble.

14 establishes the State's tripartite levels of obligations towards the right to health.⁵⁴⁶ Thus, the FCTC recognizes the State's obligation to protect public health through tobacco control.

The FCTC was advanced as a response to the “globalization of the tobacco epidemic.”⁵⁴⁷ It is possible to establish a parallel between the globalization of tobacco and the globalization of ultra-processed food and sweetened beverages. The spread of transnational companies worldwide contributed to the rise in unhealthy food consumption. As a result, NCDs related to unhealthy diets are growing.⁵⁴⁸ Nevertheless, there isn't a legally binding response to the globalization of unhealthy food at the international framework.

The aim of the FCTC is “to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke.”⁵⁴⁹ To achieve this goal, Art. 4 introduces the guiding principles: the need to raise public awareness; a political commitment to develop and maintain comprehensive multisectoral measures and coordinated responses; international cooperation; to consider taking action to deal with criminal and civil liability; to provide assistance for tobacco workers and growers; and to ensure the participation of civil society.⁵⁵⁰

2 Article 5.3

The general obligations of the FCTC require parties to establish essential infrastructure for tobacco control, including a national coordinating mechanism, and to develop and implement comprehensive, multisectoral tobacco-control strategies, plans, and legislation to prevent and reduce tobacco use, nicotine addiction, and exposure to tobacco smoke.⁵⁵¹ Art. 5.3 emphasizes that parties must protect public health policies from commercial and other vested interests of the tobacco industry.⁵⁵² Along the same lines, the preamble of FCTC calls attention to “the need to be alert to any efforts by the tobacco industry to undermine or subvert tobacco control efforts and the need to be informed of activities of the tobacco industry that have a negative impact on

⁵⁴⁶ See Part 2, Chapter 4, I, 3 Tripartite typology of obligations.

⁵⁴⁷ Suzanne Zhou and Jonathan Liberman, ‘Chapter 12: the Global Tobacco Epidemic and the WHO Framework Convention on Tobacco Control—The Contributions of the WHO's First Convention to Global Health Law and Governance’ in Burci and Toebes, *Research Handbook on Global Health Law* (Edward Elgar Publishing 2018) 344.

⁵⁴⁸ Part 1, Chapter 1.

⁵⁴⁹ WHO Framework Convention on Tobacco Control (n 31) art 3.

⁵⁵⁰ *ibid*, art 4.

⁵⁵¹ *ibid*, art 5.

⁵⁵² *ibid*, 5.3.

tobacco control efforts”. Taking into account that the issue of conflict of interests and the corporate influence of food and sweetened beverage companies in public health is not legally recognized at the international level, Art. 5.3 deserves a detailed analysis.

The Conference of the Parties (COP) is the WHO FCTC’s governing body and comprises all Parties to the Convention. The COP’s mandate is to review and promote the Convention’s implementation by adopting protocols, annexes, and amendments to the Convention.⁵⁵³ The COP can also adopt guidelines that clarify and elaborate treaty obligations.⁵⁵⁴ In 2007, the COP adopted the implementation guideline of Art. 5.3 of the WHO Framework Convention on Tobacco Control. Taking into consideration the broad array of strategies and tactics used by the tobacco industry to interfere with the setting and implementation of tobacco control measures, the aim of these guidelines is to help Parties achieve their legal obligations under Art. 5.3 of the Convention.

The first principle of the guideline recognizes a fundamental and irreconcilable conflict between the tobacco industry’s and public health policy interests.⁵⁵⁵ The second principle expresses that any interaction with the tobacco industry should be transparent and accountable, and the third principle indicates that the tobacco industry must act in an accountable and transparent manner.⁵⁵⁶ The last principle, recognizing that tobacco is lethal, establishes that any preferential treatment of the tobacco industry would conflict with tobacco control policy.⁵⁵⁷

The guideline also includes a series of recommendations about tobacco industry interference in public health policies, inter alia, raising awareness about the addictive and harmful nature of tobacco products; establishing measures to limit interactions with the tobacco industry and ensuring transparency when the interactions occur; reject partnerships and non-binding or non-enforceable agreements with the tobacco industry; avoid conflicts of interest for government officials and employees; denormalize and even regulate “socially responsible” activities by the tobacco industry, including “corporate social responsibility”.⁵⁵⁸

The implementation guideline is extremely relevant to the topic of public-private partnerships for NCD prevention. From a brief analysis of the principles and recommendations presented

⁵⁵³ WHO Framework Convention on Tobacco Control (n 31) art 23.

⁵⁵⁴ Zhou and Liberman, ‘Chapter 12: the Global Tobacco Epidemic and the WHO Framework Convention’ (n 547) 352.

⁵⁵⁵ WHO Framework Convention on Tobacco Control (n 31) art 5.3.

⁵⁵⁶ *ibid.*

⁵⁵⁷ *ibid.*

⁵⁵⁸ *ibid.*

above, Art. 5.3 states the non-engagement with the tobacco industry; consequently, PPPs involving tobacco companies are thus not on the table. In particular, one of the recommendations of the guideline expressly rejects partnerships, including voluntary arrangements with the tobacco industry.⁵⁵⁹ In contrast to the tobacco industry, PPPs with food or sweetened beverage industries are not opposed per se, at least not within the normative framework of the WHO.

Nevertheless, there is a growing call to change the interactions with the food industry. For instance, recently, the European Congress on Obesity removed Nestlé as a sponsor after experts highlighted in an open letter published in the *British Medical Journal* that the “sponsorship from the food industry to an obesity congress is the same as the tobacco industry sponsoring a congress on smoking-related disease”.⁵⁶⁰ In this open letter, scholars recognized that “institutions cannot have a financial interest in causing a problem while simultaneously claiming to have an interest in effective solutions; it constitutes a conflict”. For matters of clarification, Art. 13 of FCTC bans all tobacco advertising, promotion, and sponsorship.⁵⁶¹

The implementation guidelines adopted by the COP are considered “softer norms” or are also described as “non-binding”. LIBERMAN and ZHOU explain that as a normative instrument negotiated and adopted by the agreements of all parties, these guidelines carry relevant significance in interpreting obligations under the Convention.⁵⁶² The International Law Commission of the UN referred in its draft conclusions that the WHO FCFT guidelines are considered “subsequent agreements” by the parties and therefore must be interpreted through Art. 31(3)(a) of the Vienna Convention which states that “any subsequent agreement between the parties regarding the interpretation of the treaty or the application of its provisions”.⁵⁶³ Thus, the implementation guidelines, even though being referred to with a negative connotation as “soft norms”, have a significant role in interpreting the binding provisions from the FCTC.

⁵⁵⁹ *ibid.*

⁵⁶⁰ Jacqui Wise, ‘Obesity Conference Ditches Nestlé as Sponsor after Protests’ (2023) 380 *BMJ* 737.

⁵⁶¹ WHO Framework Convention on Tobacco Control (n 31) art 13.

⁵⁶² Zhou and Liberman, ‘Chapter 12: the Global Tobacco Epidemic and the WHO Framework Convention’ (n 547) 355.

⁵⁶³ *ibid.*

3 FCTC and trade law

The FCTC has an impact on other legal regimes, such as international trade law and the WTO system.⁵⁶⁴ Some provisions of the FCTC have a direct impact on trade law. For instance, Art. 6 establishes price and tax measures to reduce the demand for tobacco, Art. 9 and 10 make provisions about product regulation, Art.11 refers to the packaging and labeling of tobacco products, and Art. 13 sets out conditions for tobacco advertising, promotion, and sponsorship.⁵⁶⁵

A milestone in the context of tobacco control is the 2010 Punta Del Este Declaration, which reaffirmed the state's right to protect public health through tobacco control measures under the GATT, TBT agreement, and the Trips Agreement.⁵⁶⁶

There have been several cases that show the conflict between FCTC and trade agreements. For instance, in the case Philip Morris v. Uruguay, Philip Morris International filed an international arbitration lawsuit against Uruguay, claiming that two of the country's tobacco control laws violated a Bilateral Investment Treaty between Uruguay and Switzerland.⁵⁶⁷ The two laws challenged by Philip Morris required 80% graphic health warnings on cigarette packs and limited tobacco brands to a single-brand variant. The award addressed fundamental legal issues concerning the balance between investor rights and the space available for states to regulate public health under international investment law. The tribunal affirmed the importance of the FCTC (even though Switzerland has never ratified the treaty), deciding that the measures adopted by Uruguay were reasonable, evidence-based, and part of the obligation to protect public health.⁵⁶⁸

V Non-binding instruments

⁵⁶⁴ Part 2, Chapter 4, IV.

⁵⁶⁵ WHO Framework Convention on Tobacco Control (n 31).

⁵⁶⁶ Lawrence O Gostin and Benjamin Mason Meier (eds), *Foundations of Global Health & Human Rights* (Oxford University Press 2020) 356.

⁵⁶⁷ Gostin, *Global Health Law* (n 3) 253.

⁵⁶⁸ Zhou and Liberman, 'Chapter 12: the Global Tobacco Epidemic and the WHO Framework Convention' (n 547) 375-379.

1 United Nations General Assembly

The UN General Assembly is the principal policy-making organ of the United Nations.⁵⁶⁹ Established in 1945 under the Charter of the United Nations, it is comprised of all 193 Members and plays a central role in standard-setting and codifying international law.⁵⁷⁰ The General Assembly reflects the political will of all Member States.⁵⁷¹

1.1 High-level Meeting on NCDs

In 2011, at the High-level Meeting on NCDs, the United Nations General Assembly discussed a health topic for the second time. The first time was to discuss HIV/AIDS in 2001, which resulted in the Declaration of Commitment on HIV/AIDS, a coordinated global response to address HIV/AIDS.⁵⁷² As a result of the High-level Meeting in 2011, the UN General Assembly adopted the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, which did not have the same impact as the previous meeting to tackle HIV. Critics of the Political Declaration agreed that it lacks concrete measures and strong commitments to fight the complexities of the NCDs.⁵⁷³

The Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases highlighted the main NCDs (cardiovascular disease, cancers, diabetes, and chronic respiratory diseases) and the four common main risk factors (tobacco use, unhealthy use of alcohol, unhealthy diet, and physical inactivity), the 4 × 4 approach.⁵⁷⁴ It presents the global challenges imposed by NCDs and calls for a whole-of-government and a whole-of-society response. In addition, it commits to reducing risk factors and creating health-promoting environments, strengthening national policies and health

⁵⁶⁹ United Nations, 'Workings of the General Assembly' (UN) <<https://www.un.org/en/ga/>> accessed 06 April 2023.

⁵⁷⁰ Charter of the United Nations (adopted 26 June 1945, entered into force 24 October 1945) 1 UNTS XVI art 13.

⁵⁷¹ Nick Banatvala, Werner Obermeyer and George Alleyne, 'Chapter 31: United Nations High-Level Meetings on NCD Prevention and Control' in Nick Banatvala and Pascal Bovet, *Noncommunicable Diseases: A Compendium* (Routledge 2023) 230.

⁵⁷² Gostin, *Global Health Law* (n 3) 406 art 6.

⁵⁷³ Kavita Sivaramakrishnan and Richard G Parker, 'The United Nations High Level Meeting on the Prevention and Control of Noncommunicable Diseases: A Missed Opportunity?' (2012) 102 *American Journal of Public Health* 2010.

⁵⁷⁴ UN General Assembly, 'Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases : draft resolution / submitted by the President of the General Assembly' (6 September 2011) UN Doc A/66/L.1.

systems, and international cooperation, including collaborative partnerships, research and development, monitoring, and evaluation.⁵⁷⁵

The Political Declaration recognizes the government's primary role and responsibility in tackling non-communicable diseases.⁵⁷⁶ From a human rights-based approach, the interpretation can be made here of the tripartite typology of obligations of States towards the fulfillment of the right to the highest attainable standard of health.

The Political Declaration recognizes the importance of strengthening the coordination of all relevant stakeholders, including the private sector and industry, for non-communicable disease prevention and control.⁵⁷⁷ Regarding conflict of interest, it acknowledged the fundamental conflict of interest only between the tobacco industry and public health, not expanding to other sectors of risk creators for NCDs, such as the food and sweetened beverage industries.⁵⁷⁸

Paragraph 44 of the Political Declaration, *inter alia*, calls upon the private sector to advance measures to implement the WHO set of recommendations to reduce the impact of the marketing of unhealthy foods and non-alcoholic beverages to children, reformulation of products to provide healthier options that are affordable and accessible reduction of salt in the food industry.⁵⁷⁹

In 2014, the Second High-level Meeting focused on the review and assessment of the progress achieved in the prevention and control of noncommunicable diseases since 2011 and provided a set of national and international commitments and actions to enhance efforts toward a world free of the avoidable burden of NCDs.⁵⁸⁰ Moreover, the Second High-level Meeting recognized the limited progress made in implementing paragraph 44 of the Political Declaration of the High-level Meeting of the General Assembly on the prevention and control of non-communicable diseases, highlighting that healthy food products were still not affordable, accessible, and available.⁵⁸¹ In addition, reinforced the call for multisectoral approaches to health.

⁵⁷⁵ *ibid.*

⁵⁷⁶ *ibid.*, para 3.

⁵⁷⁷ *ibid.*, para 37.

⁵⁷⁸ *ibid.*, para 38.

⁵⁷⁹ UN General Assembly, 'Political Declaration of the High-Level Meeting of the General Assembly' (n 574) para 44.

⁵⁸⁰ UN General Assembly, 'Outcome document of the High-Level Meeting of the General Assembly on the Comprehensive Review and Assessment of the Progress Achieved in the Prevention and Control of Non-communicable Diseases : draft resolution / submitted by the President of the General Assembly' (7 July 2014) UN Doc A/RES/68/300.

⁵⁸¹ *ibid.*, para 26.

The Second High-level Meeting also welcomed the establishment of the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases.⁵⁸² And the Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases (GCM/NCD).⁵⁸³

The Third High-Level Meeting, in 2018, reaffirmed political commitment to accelerate the implementation of the 2011 Political Declaration, and the 2014 outcome document called upon multistakeholder and multisectoral responses to the prevention and control of NCDs in the context of the 2030 Agenda for Sustainable Development.⁵⁸⁴ The 2018 Political Declaration included mental health and air pollution in the NCD agenda (moving from the 4 × 4 approach to the 5 × 5 approach). Once again, there is a call for engagement with the private sector and for the private sector to strengthen its commitment and contribution to implementing national responses to prevent, control, and treat non-communicable diseases.⁵⁸⁵

1.2 Sustainable Development Goals

In September 2015, the international community agreed upon a new global development agenda, replacing the former 2000 Millennium Development Goals. Through Resolution 70/1, the United Nations General Assembly adopted the 2030 Agenda for Sustainable Development.⁵⁸⁶ This document presents the 17 Sustainable Development Goals, which, through three dimensions, economic, social, and environmental, aim to end poverty and hunger, protect human rights and human dignity, protect the planet from degradation, and foster peace.⁵⁸⁷

The SDGs are considered a landmark concerning NCDs because it was the first time noncommunicable diseases were included in a global development agenda. The challenges imposed by NCDs directly impact each element of the “triple bottom line”: social, economic, and environmental.⁵⁸⁸ The social impacts of NCDs are harsher on people of low economic status, generating inequalities.⁵⁸⁹ In addition, NCDs affect employment opportunities and are

⁵⁸² *ibid*, para 9.

⁵⁸³ *ibid*, para 11.

⁵⁸⁴ UNGA, ‘Political declaration of the 3rd High-Level Meeting’ (n 68) para 1.

⁵⁸⁵ *ibid*, para. 16, 43, 44, 46.

⁵⁸⁶ UN General Assembly, ‘Transforming our world : the 2030 Agenda for Sustainable Development : draft resolution referred to the United Nations summit for the adoption of the post-2015 development agenda by the General Assembly at its 69th session’ (18 September 2015) UN Doc A/RES/70/1.

⁵⁸⁷ *ibid*.

⁵⁸⁸ Garde, ‘Chapter 13: Global Health Law and Non-Communicable Disease Prevention’ (n 37) 395.

⁵⁸⁹ Part 1, Chapter 1, II. NCD risk distribution and social determinants of health.

related to poor quality of life, poor health, and lower life expectancy.⁵⁹⁰ Economically, they represent a vast burden for healthcare systems worldwide, and because of lower productivity and employment, they have a negative impact on labor markets.⁵⁹¹ Finally, in the environmental line, recent studies have shown the interdependency between environmental risk factors and NCDs.⁵⁹²

Goal 3 of the SDGs is to ensure healthy lives and promote well-being for all at all ages. Specifically, SDG target 3.4 aims to “by 2030, reduce by one-third premature mortality from NCDs through prevention and treatment and promote mental health and wellbeing”.⁵⁹³ In addition, target 3.5 addresses substance abuse, including harmful use of alcohol, target 3.a a focus on improvements in tobacco control, and target 3.b focuses on supporting research and development of vaccines and medicines for NCDs that primarily affect developing countries, as well as providing access to affordable essential medicines and vaccines for NCDs. Thus, NCD prevention is clearly part of the agenda for Sustainable Development.

Furthermore, Goal 2, “end hunger, achieve food security and improved nutrition and promote sustainable agriculture,” is interrelated with the right to health and NCDs.⁵⁹⁴ In particular, target 2.1 comprises “access by all people to safe, nutritious and sufficient food all year round,” and target 2.2 aims to end all forms of malnutrition by 2030.⁵⁹⁵ Therefore, Goal 2 of the SDGs is also indirectly related to the prevention of NCDs.

2 World Health Assembly

The WHA is the decision-making body of the WHO.⁵⁹⁶ The WHA is comprised of delegations from all WHO Member States and focuses on a specific health agenda prepared by the Executive Board.⁵⁹⁷ The functions of the World Health Assembly are listed in Art. 18 of the WHO Constitution, which is the main function of determining the policies of the Organization,

⁵⁹⁰ Garde, ‘Chapter 13: Global Health Law and Non-Communicable Disease Prevention’ (n 37) 395.

⁵⁹¹ *ibid.*

⁵⁹² Meghnath Dhimal, Tamanna Neupane and Mandira Lamichhane Dhimal, ‘Understanding Linkages between Environmental Risk Factors and Noncommunicable Diseases—a Review’ (2021) 3 FASEB BioAdvances 287.

⁵⁹³ UNGA, ‘Transforming our world : the 2030 Agenda for Sustainable Development’ (n 593).

⁵⁹⁴ The right to food is an underlying determinant of health. See Part 2, Chapter 4, III, 2 Right to adequate food.

⁵⁹⁵ UNGA, ‘Transforming our world : the 2030 Agenda for Sustainable Development’ (n 593).

⁵⁹⁶ Gostin, *Global Health Law* (n 3) 93.

⁵⁹⁷ World Health Organization, *World Health Assembly (WHO)* <<https://www.who.int/about/governance/world-health-assembly>> accessed 10 April 2023.

appointing the Director-General, supervising financial policies, and reviewing and approving the proposed program budget.⁵⁹⁸

In May 1998, the fifty-first World Health Assembly recognized in the resolution WHA51.18 that non-communicable diseases were a growing problem that already represented a significant burden on public health services, and NCDs were responsible for high rates of mortality, morbidity, and disability.⁵⁹⁹ At this same resolution, the WHA requested the Director-General to develop a global strategy for the prevention and control of noncommunicable diseases. Moreover, the resolution encourages cooperation with the private sector.⁶⁰⁰

2.1 WHO Global Strategies⁶⁰¹

WHO Global Strategy for the Prevention and Control of NCDs

In March 2000, the World Health Assembly endorsed the WHO Global Strategy for the Prevention and Control of NCDs, focusing on the four principal non-communicable diseases: cardiovascular disease, cancer, chronic obstructive pulmonary disease, and diabetes, with the aim to support Member States in their efforts to reduce the toll of morbidity, disability, and premature mortality related to non-communicable diseases.⁶⁰²

The strategy's three main objectives are (i) to map the epidemic in order to understand the burden of NCDs and their determinants and trends in order to guide policy and programming; (ii) to reduce the level of exposure of individuals and populations to the common risk factors and their determinants; and (iii) to strengthen healthcare for people with NCDs through cost-effective interventions.⁶⁰³ In addition, the key elements to achieve the aforementioned objectives are surveillance, health and prevention promotion, and health sector management.⁶⁰⁴

Analyzing the WHO Global Strategy for the Prevention and Control of NCDs, some paragraphs deserve better attention. Paragraph 10 highlights that for community-based interventions to

⁵⁹⁸ WHO, *Constitution of the World Health Organization* (n 383).

⁵⁹⁹ World Health Assembly, 'Noncommunicable Disease Prevention and Control' WHA Res 51.18 (16 May 1998).
⁶⁰⁰ *ibid.*

⁶⁰¹ This analysis does not address the WHO Global Strategy to Reduce the Harmful Use of Alcohol, but instead focuses specifically on unhealthy diets.

⁶⁰² WHO, 'Global strategy for the prevention and control of noncommunicable diseases' WHO Doc A53/14 (n 514), para 5 and 14.

⁶⁰³ *ibid.*, para 15.

⁶⁰⁴ *ibid.*, para 16.

successfully prevent NCDs, they must collaborate with nongovernmental organizations, industry, and the private sector.⁶⁰⁵ In addition, paragraph 11 points out that health gains through prevention cannot be achieved solely by changes in health policy. But with decisions outside the health sector, such as trade, food, pharmaceutical production, agriculture, urban development, and taxation policies.⁶⁰⁶

WHO Global Strategy on Diet, Physical Activity and Health

In 2004, the 57th World Health Assembly endorsed the World Health Organization's Global Strategy on Diet, Physical Activity and Health. As expressed in the name, the Global Strategy addresses two of the main risk factors for noncommunicable diseases, namely, diet and physical activity. The main objectives are (i) reduction of the risk factors related to unhealthy diets and physical inactivity through prevention measures; (ii) raise awareness of the impact of diet and physical activity on health; (iii) implementation of global, regional, national, and community policies and action plan to improve diets and increase physical activity engaging all sectors, including the private sector; (iv) to support research and monitoring scientific data and key influences on diet and physical activity.⁶⁰⁷

The Global Strategy makes recommendations to governments, the WHO, civil society, nongovernmental organizations, and the private sector related to the promotion of individual and community health through healthy diet and physical activity and reducing the risks and incidence of non-communicable diseases.⁶⁰⁸ It is relevant to highlight that the Strategy encourages the participation of the private sector.

It explicitly states that "Governments are encouraged to consult with stakeholders on policy."⁶⁰⁹ It explains that "member states should establish mechanisms to promote participation of nongovernmental organizations, civil society, communities, the private sector and the media in activities related to diet, physical activity and health."⁶¹⁰

⁶⁰⁵ *ibid*, para 10.

⁶⁰⁶ *ibid*, para 11.

⁶⁰⁷ WHO, Global Strategy on Diet, Physical Activity and Health (n 466) para 18.

⁶⁰⁸ *ibid*.

⁶⁰⁹ *ibid*, para 44.

⁶¹⁰ *ibid*.

Furthermore, at the WHO level, it affirms that WHO “will hold discussions with the transnational food industry and other parts of the private sector in support of the aims of the Strategy, and of implementing the recommendations in countries.”⁶¹¹

Finally, paragraph 61 points to the relevant role the private sector can play in the prevention of NCDs, mentioning the positive outcomes of cooperation with the food industry to reduce the fat, sugar, and salt content of processed foods and portion sizes.⁶¹² The Strategy also underscores that the food industry, retailers, catering companies, sporting goods manufacturers, advertising and recreation businesses, insurance and banking groups, pharmaceutical companies “all have important parts to play as responsible employers and as advocates for healthy lifestyles”.⁶¹³

2.2 The WHO Global Action Plan for the Prevention and Control of NCDs

In 2008, the WHA endorsed the Global Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases, which established six objectives to be implemented between 2008–2013: (i) raise the priority to noncommunicable disease at global and national levels, integrating the prevention and control of NCDs; (ii) strengthen national policies the prevention and control of noncommunicable diseases; (iii) promote interventions to reduce tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol (the modifiable risk factors for NCDs); (iv) promote research for the prevention and control of noncommunicable diseases; (v) promote partnerships for the prevention and control of noncommunicable diseases (vi) to monitor and evaluate the progress at the national, regional and global levels.⁶¹⁴

Objective 3 of the Global Action Plan focuses on strategies for reducing risk factors for noncommunicable diseases and aims to provide and encourage healthy choices.⁶¹⁵ It affirms the inclusion of multisectoral actions and following the line of paragraph 11 of the WHO Global Strategy for the Prevention and Control of NCDs emphasizes that to achieve more health gains

⁶¹¹ *ibid*, para 50.

⁶¹² *ibid*, para 61.

⁶¹³ *ibid*.

⁶¹⁴ World Health Organization, *Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2008-2013* (WHO 2008).

⁶¹⁵ *ibid*.

in prevention it needs to influence public policies in domains such as trade, food and pharmaceutical production, agriculture, urban development, and taxation policies.⁶¹⁶

In addition, objective 5, titled “to promote partnerships for the prevention and control of non-communicable diseases,” encourages the establishment of partnerships, including inter alia the business community.⁶¹⁷ It highlights that the resources for the prevention and control of non-communicable diseases are limited in most national and institutional budgets, and therefore, these partnerships are vital.⁶¹⁸

As a successor to the WHO Global NCD Action Plan 2008–2013, in 2013, the WHO Global NCD Action Plan 2013–2020 (NCD GAP) was established. The NCD GAP was initially developed for 2013–2020, but in 2019, it was extended to 2030. The NCD GAP goal is to reduce the preventable and avoidable burden of morbidity, mortality, and disability due to noncommunicable diseases through multisectoral collaboration and cooperation at national, regional, and global levels.⁶¹⁹ It sets as overarching principles and approaches: (i) human rights approach; (ii) equity-based approach; (iii) national action, international cooperation and solidarity; (iv) multisectoral action; (v) life-course approach; (vi) empowerment of people and communities; (vii) evidence-based strategies; (viii) universal health coverage; and (ix) management of real, perceived or potential conflicts of interest.⁶²⁰

The Plan provides a road map and a menu of policy options for all Member States and other stakeholders, to take coordinated and coherent action, at the local to the global level, achieving the nine voluntary global targets (at least a 10% relative reduction in harmful use of alcohol; 10% relative reduction in physical inactivity; 30% relative reduction in sodium intake; 25% relative reduction in hypertension; 80% availability and affordability of essential medicines and technologies; drug therapy and counseling for 50 % of the population; and 25% relative reduction in premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 2025, the 25x 25 campaign).⁶²¹

In summary, the six objectives proposed by the Plan are to raise greater attention and cooperation for NCDs globally, regionally, and nationally; to strengthen national multisectoral

⁶¹⁶ *ibid.*

⁶¹⁷ *ibid.*

⁶¹⁸ *ibid.*

⁶¹⁹ World Health Organization, *Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020* (WHO 2013).

⁶²⁰ *ibid.*

⁶²¹ *ibid.*

action and partnerships for NCDs; to reduce exposure to NCD risk factors and create health-promoting environments; to strengthen primary health care and promote universal health coverage; to promote the national capacity for high-quality research and development on NCDs; to monitor the trends and determinants of noncommunicable diseases and evaluate progress in their prevention and control.⁶²² Once again, there is an encouragement of a multisectoral approach, mentioning partnerships and “constructive engagement with relevant private sector actors.”⁶²³

In addition, the Plan clarifies that non-state actors include private sector entities but exclude the tobacco industry, including the entities that “are demonstrably committed to promoting public health and are willing to participate in public reporting and accountability frameworks.”⁶²⁴ Moreover, one of the overarching principles is the management of real, perceived, or potential conflicts of interest. However, it doesn’t provide specific guidelines for the conflict of interest of the unhealthy food and sweetened beverage industries.

The GAP contains five appendices. Appendix 1 is titled “synergies between major noncommunicable diseases and other conditions”; Appendix 2 is “comprehensive global monitoring framework, including 25 indicators, and a set of nine voluntary global targets for the prevention and control of noncommunicable diseases”; Appendix 3 is “menu of policy options and cost-effective interventions for prevention and control of major noncommunicable diseases”; Appendix 4 is “examples of collaborative division of tasks and responsibilities” which concerns a provisional list only. A division of labor is being developed by the United Nations funds, programs, and agencies, and Appendix 5 “examples of cross-sectoral government engagement to reduce risk factors and potential health effects of multisectoral action.”⁶²⁵

Appendix 3 presents a non-exhaustive list of options for each of the four key risk factors for NCDs (tobacco, harmful use of alcohol, unhealthy diet, and physical inactivity) and the four disease areas (cardiovascular disease, diabetes, cancer, and chronic respiratory disease).⁶²⁶ Moreover, Appendix 3 has been updated due to new evidence of cost-effectiveness. In 2017, the revision of Appendix 3 was endorsed by the World Health Assembly, and it was renamed

⁶²² *ibid.*

⁶²³ *ibid.*

⁶²⁴ *ibid.*

⁶²⁵ *ibid.*

⁶²⁶ *ibid.*

“best buys” and other recommended interventions.⁶²⁷ This updated version includes a total of 88 interventions, including overarching/enabling policy actions, the most cost-effective interventions, and other recommended interventions.⁶²⁸

In 2022, the WHA adopted an implementation roadmap 2023–2030 for the Global Action Plan for the Prevention and Control of NCDs 2013–2030. The aim of the implementation roadmap is to accelerate progress where actions have not been effective in the prevention of NCDs.⁶²⁹ Paragraph 32 of the implementation roadmap calls attention to the fact that countries should devise clear rules and rigorous approaches for engagement with the private sector that prevent, identify, and manage real or potential conflicts of interest, ensuring that the engagements support the specific objectives of national NCD responses.⁶³⁰

2.3 Best Buys

The 2017 revision of Appendix 3 of the WHO Global NCD Action Plan created the best buys, which is a package of 16 affordable, cost-effective, and evidence-based NCD interventions. The NCD Best Buys focus on addressing the major NCD risk factors (tobacco use, harmful alcohol use, unhealthy diets, and inadequate physical activity) and the management of priority disease areas (cardiovascular disease, diabetes, and cervical cancer).⁶³¹ Best buys are considered the interventions where there is an average cost-effectiveness ratio of \leq \$ 100 per DALY averted in low- and lower-middle-income countries.⁶³² In addition, Best Buy’s main advantage would be the feasibility of its implementation. Moreover, it was created to help policymakers focus on interventions that have a high impact at an affordable cost and not be swamped by countless policy options and interventions.⁶³³

⁶²⁷ World Health Organization, *Tackling NCDs: 'best buys' and other recommended interventions for the prevention and control of noncommunicable diseases* (WHO 2017) <<https://apps.who.int/iris/handle/10665/259232>>.

⁶²⁸ *ibid.*

⁶²⁹ World Health Organization, *Draft implementation road map 2023–2030 for the global action plan for the prevention and control of noncommunicable diseases 2013–2030*, Seventy-fifth World Health Assembly, Provisional agenda item 14.1, A75/10 Add. 8 (2022).

⁶³⁰ World Health Organization, ‘WHO Discussion Paper on the development of an implementation roadmap 2023–2030 for the WHO Global Action Plan for the Prevention and Control of NCDs 2023–2030’ (WHO 2021) <<https://www.who.int/publications/m/item/implementation-roadmap-2023-2030-for-the-who-global-action-plan-for-the-prevention-and-control-of-ncds-2023-2030>>.

⁶³¹ WHO, *Tackling NCDs: 'best buys' and other recommended interventions* (n 627).

⁶³² *ibid.*

⁶³³ Nick Banatvala and others, ‘Chapter 34: Best Buys and other Recommended Interventions for NCD Prevention and Control’ in Nick Banatvala and Pascal Bovet, *Noncommunicable Diseases: A Compendium* (Routledge 2023) 246.

For tobacco use, the best buys interventions are: increase excise taxes and prices on tobacco products; implement plain/standardized packaging and/or large graphic health warnings on all tobacco packages; enact and enforce comprehensive bans on tobacco advertising, promotion and sponsorship; eliminate exposure to second-hand tobacco smoke in all indoor workplaces, public places and public transport; implement effective mass-media campaigns that educate the public about the harms of smoking/tobacco use and second-hand smoke.⁶³⁴

To reduce the harmful use of alcohol, the best buys are: increase excise taxes on alcoholic beverages; enact and enforce bans or comprehensive restrictions on exposure to alcohol advertising (across multiple types of media); enact and enforce restrictions on the physical availability of alcohol in sales outlets (via reduced hours of sale).⁶³⁵

To promote healthy diets: reduce salt intake through the reformulation of food products to contain less salt, and the setting of maximum permitted levels for the amount of salt in food; reduce salt intake through establishing a supportive environment in public institutions such as hospitals, schools, workplaces, and nursing homes, to enable low-salt options to be provided; reduce salt intake through behavior change communication and mass-media campaigns; reduce salt intake through the implementation of front-of-pack labeling.⁶³⁶ It is important to observe that interventions towards sugar or trans-fat do not fit the cost-effectiveness ratio of \leq \$ 100 per DALY; thus, it's not part of the best buy intervention. However, sugar, in particular sweetened beverages, is one of the main contributors to an unhealthy diet.

To reduce physical inactivity: implement community-wide public education and awareness campaigns for physical activity, including mass-media campaigns combined with other community-based education, and motivational and environmental programs aimed at supporting behavioral change around physical activity levels.⁶³⁷

To manage cardiovascular disease and diabetes: provide drug therapy (including glycemic control for diabetes mellitus and control of hypertension using a total-risk approach) and counselling for individuals who have had a heart attack or stroke and for persons with high risk (\geq 30%) of a fatal or non-fatal cardiovascular event in the next 10 years.⁶³⁸

⁶³⁴ World Health Organization, *Saving lives, spending less: a strategic response to noncommunicable diseases* (WHO/NMH/NVI/18.8, Geneva 2018).

⁶³⁵ *ibid.*

⁶³⁶ WHO, *Tackling NCDs: 'best buys' and other recommended interventions* (n 627).

⁶³⁷ *ibid.*

⁶³⁸ *ibid.*

As can be concluded, the major criterion for Best Buys is cost-effectiveness. However, the first problem is that the evidence for Best Buys is based on effectiveness data from high-income countries, and cost-effectiveness varies across countries due to various factors such as disease profiles, population characteristics, health systems, and local characteristics.⁶³⁹

VI Other relevant initiatives to the prevention of NCDs

Since the growing burden of NCDs, the WHO has adopted multiple measures focusing on the prevention of these diseases, such as toolkits, conferences, campaigns, reports, and countless publications. For reasons of limitation, this thesis only analyzed the most relevant instruments in the framework of global health law, and below, it presents another significant initiative for NCD prevention.

1 UN Inter-Agency Task Force on the Prevention and Control of NCDs

In 2013, the Economic and Social Council established the United Nations Interagency Task Force on the Prevention and Control of Non-communicable Diseases which aims to “coordinate the activities of the relevant United Nations funds, programs and specialized agencies and other intergovernmental organizations to support the realization of the commitments made by Heads of State and Government in the political declaration of the high-level meeting of the General Assembly on the prevention and control of non-communicable diseases” focusing in the implementation WHO Global NCD Action Plan 2013-2020.⁶⁴⁰

The Task Force reports each year to the Economic and Social Council of the United Nations. In two opportunities, the meetings have focused on legal matters for the implementation of effective NCD prevention strategies. In 2006, in a workshop about NCDs and the law, the Task Force committed to conducting a study on how the UN system could meet the demand for technical assistance in the intersection of law and NCDs.⁶⁴¹ And in the next year, specifically focusing on human rights. As a result, in 2017, the Montevideo Road Map 2018-2030 refers to

⁶³⁹ Banatvala and others, ‘Chapter 34: Best Buys and other Recommended Interventions’ (n 633) 251.

⁶⁴⁰ UN Economic and Social Council, *Resolution adopted by the Economic and Social Council on 22 July 2013 (E/RES/2013/12, 2013)* establishing the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases.

⁶⁴¹ Garde, ‘Chapter 13: Global Health Law and Non-Communicable Disease Prevention’ (n 37) 393.

the UN Interagency Task Force as the central point of the UN system for the use of law to prevent and control NCD.⁶⁴²

2 WHO NCD Global Monitoring Framework

In 2013, the World Health Assembly adopted the WHO NCD Global Monitoring Framework to track global, regional, and national progress in addressing the burden of NCDs.⁶⁴³ It consists of 25 indicators across three areas, which focus on the key outcomes, risk factors, and national systems response needed to prevent and control NCDs.⁶⁴⁴

The nine targets comprised in the framework are the global targets established in the Global NCD Action Plan 2008–2013. Thus, the nine areas are one mortality target, six risk factor targets (harmful use of alcohol, physical activity, dietary sodium intake, tobacco use, raised blood pressure, and diabetes and obesity), and two national systems targets (drug therapy to prevent heart attacks and strokes, and essential NCD medicines and technologies to treat major NCDs). Countries are encouraged to use these global targets as a guide to set national targets in their national multisectoral action plans.⁶⁴⁵

The framework's goal is to advance progress in the prevention and control of NCDs, providing the foundation for advocacy, raising awareness, reinforcing political commitment, and promoting global action to tackle NCDs.⁶⁴⁶

3 Global Coordination Mechanism on the Prevention and Control of NCDs

In 2014, the World Health Assembly established the Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases (GCM/NCD) which aims to facilitate and enhance the coordination of activities, multi-stakeholder engagement, and action across sectors at the local, national, regional and global levels, in order to contribute to the

⁶⁴² *ibid.*

⁶⁴³ World Health Organization, *World Health Assembly, 66. Follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases* WHA66.10 (2013).

⁶⁴⁴ Nick Banatvala and others, 'Chapter 35: Accountability for NCD Prevention and Control' in Nick Banatvala and Pascal Bovet, *Noncommunicable Diseases: A Compendium* (Routledge 2023) 253.

⁶⁴⁵ World Health Organization, *NCD Global Monitoring Framework* (WHO 2011) <<https://www.who.int/publications/i/item/ncd-surveillance-global-monitoring-framework>> accessed 10 April 2023.

⁶⁴⁶ *ibid.*

implementation of the WHO Global NCD Action Plan 2013–2020.⁶⁴⁷ The GCM/NCD’s main functions are advocacy and raising awareness, disseminating knowledge and information, encouraging innovation and identifying barriers, advancing multisectoral action, and advocating for the mobilization of resources.⁶⁴⁸

The GCM/NCD is led by Member States and includes United Nations funds, programs, and organizations, and other relevant intergovernmental organizations and non-State actors (NGOs, academia, philanthropic foundations, and the private sector).⁶⁴⁹ The interaction between participants is done through working groups, global multi-stakeholder dialogue meetings, an extensive network of communities of practice, webinars, integrated country initiatives, and knowledge dissemination and advocacy at global, regional, and country levels.⁶⁵⁰

The GCM/NCD is in compliance with the UN General Assembly and World Health Assembly resolutions that call for the shared responsibility of all stakeholders across sectors to prevent NCDs. In addition, the WHO acknowledges that no single organization, actor, or sector can address the burden of NCDs alone.⁶⁵¹

⁶⁴⁷ World Health Organization, *Terms of Reference of the Global Coordination Mechanism on the Prevention and Control of Noncommunicable Diseases* A67/14 Add.1 (2014).

⁶⁴⁸ *ibid.*

⁶⁴⁹ *ibid.*

⁶⁵⁰ Téa Collins, Bente Mikkelsen and Svetlana Axelrod, ‘Interact, Engage or Partner? Working with the Private Sector for the Prevention and Control of Noncommunicable Diseases’ (2019) 9 *Cardiovascular Diagnosis and Therapy* 158.

⁶⁵¹ World Health Organization, Knowledge Action Portal on NCDs. What is the WHO GCM/NCD? (*Knowledge Action Portal*) <https://www.knowledge-action-portal.com/en/about/what_is_gcmncd> accessed 10 April 2023.

CHAPTER 6: THE EUROPEAN UNION'S RESPONSES

I Legal competences

At the European Level, Art. 168(1) of the Treaty on the Functioning of the European Union (TFEU) mandates that “a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities”.⁶⁵² It has been described that this “health protection” is a horizontal (‘mainstreaming’) obligation that acts as “Health in All Policies” and must be considered in all fields of EU action.⁶⁵³ Consequently, health interests must be balanced against potentially competing policy objectives, reinforcing the EU’s authority to enact binding regulations when necessary.⁶⁵⁴

Art. 168 TFEU reflects the EU’s commitment to safeguarding and improving public health while fostering cooperation and coordination among member states to address health challenges collectively. The EU aims to complement national policies employing its health strategy to prevent illness/disease by promoting healthier lifestyles; to facilitate access to better and safer healthcare; to contribute to innovative, efficient and sustainable health systems; deal with cross-border threats; to keep people healthy throughout their lifetimes and harness new technologies and practices.⁶⁵⁵ However, the EU has limited powers in public health-related issues.⁶⁵⁶ Art. 168 (5) explicitly excludes “any harmonization of the laws and regulations of the Member States,” underscoring the Union’s limited competence, which cannot extend to harmonizing national laws and regulations.⁶⁵⁷

In addition, Art. 5.1 of the Treaty on the European Union states that “the limits of Union competencies are governed by the principle of conferral.”⁶⁵⁸ According to the principle of conferral, the EU can only act if it has been granted competence; if not, the responsibility remains with EU Member States.⁶⁵⁹

⁶⁵² Treaty on the Functioning of the European Union (consolidated version) [2012] OJ C326/47 art 168.

⁶⁵³ Amandine Garde, ‘The Lack of Coherence in the European Union’s Approach to Noncommunicable Disease Prevention’ in David Orentlicher and Tamara K Hervey (eds), *The Oxford Handbook of Comparative Health Law* (Oxford Handbooks 2021).

⁶⁵⁴ Alberto Alemanno and Amandine Garde, ‘Chapter 13: European Union’ in Tania Voon, Andrew Mitchell and Jonathan Liberman, *Regulating Tobacco, Alcohol and Unhealthy Foods: the Legal Issues* (Routledge 2014) 263.

⁶⁵⁵ European Union, ‘Public Health’ (EUR-Lex Glossary) <<https://eur-lex.europa.eu/EN/legal-content/glossary/public-health.html>> accessed 4 November 2023.

⁶⁵⁶ Alemanno and Garde, ‘Chapter 13: European Union’ (653) 259.

⁶⁵⁷ TFEU (n 652) art 168(5).

⁶⁵⁸ TFEU (n 652) art 5.1.

⁶⁵⁹ Alemanno and Garde, ‘Chapter 13: European Union’ (653) 262.

The principles of subsidiarity and proportionality also govern the use of Union competences.⁶⁶⁰ According to the principle of subsidiarity, the EU can only act “if and in so far as the objectives of the proposed action cannot be sufficiently achieved by the Member States.”⁶⁶¹ In other words, it adds value to action at the national or local level.⁶⁶²

Beyond Art. 168, other Treaty provisions provide distinct legal bases for EU health and food law action. Art. 43 TFEU grants competence in the area of agriculture, allowing the EU to adopt measures for the common organization of agricultural markets and achieve the Common Agricultural Policy (CAP) objectives outlined in Art. 39 TFEU, such as productivity enhancement, market stabilization, and ensuring reasonable prices.⁶⁶³

Meanwhile, Art. 114 TFEU serves as a general basis for harmonizing measures necessary for establishing and ensuring the functioning of the internal market.⁶⁶⁴ This provision has been pivotal in regulating the marketing of processed foodstuffs that do not fall under the scope of agricultural policy.⁶⁶⁵ Moreover, Art. 169 TFEU, concerning consumer protection, provides the EU with shared competence under Art. 4(2)(f) TFEU. This enables the EU to adopt measures aimed at protecting consumer health and safety, thereby complementing national efforts.⁶⁶⁶

It has been noted that most EU legislation relevant to NCD prevention has been adopted based on Art. 114 of the TFEU.⁶⁶⁷ This provision explicitly requires the Commission, when proposing harmonization measures relating to health, safety, environmental, and consumer protection, to ensure a high level of protection, highlighting the idea of “Health in All Policies”.⁶⁶⁸

⁶⁶⁰ TFEU (n 652) art 5.1.

⁶⁶¹ TFEU (n 652) art 5.3.

⁶⁶² Alemanno and Garde, ‘Chapter 13: European Union’ (653) 265.

⁶⁶³ Wieke Willemijn Huizing Edinger, ‘Food Health Law: A Legal Perspective on EU Competence to Regulate the “Healthiness” of Food’ (2014) 9 *European Food and Feed Law Review* 11 <<http://www.jstor.org/stable/24326010.%20Accessed%203%20Apr.%202025>> accessed 3 April 2025.

⁶⁶⁴ TFEU (n 652) art 144.

⁶⁶⁵ Wieke Willemijn Huizing Edinger, ‘Food Health Law: A Legal Perspective on EU Competence’ (n 663).

⁶⁶⁶ *ibid.*

⁶⁶⁷ Garde, ‘The Lack of Coherence in the European Union’s Approach to Noncommunicable Disease Prevention’ (n 653).

⁶⁶⁸ *ibid.*

1 EU NCD risk regulation

As a result of the severe health impacts and social and economic costs of diet-related disease, there have also been attempts at the regional level to tackle NCDs.⁶⁶⁹ At the European level, the strategies have been adopted separately by major risk factors. Regarding tobacco, the Tobacco Products Directive was implemented in 2001 and has been complemented by the Tobacco Advertising Directive in 2003 and the Council Recommendation on Smoke-Free Environment in 2009.⁶⁷⁰ In relation to alcohol, the EU Alcohol Strategy was adopted in 2006.⁶⁷¹ Finally, regarding unhealthy diets and physical inactivity, the adoption of the Green Paper on promoting healthy diets and physical activity in 2005⁶⁷² and the obesity Prevention White Paper in 2007.⁶⁷³ In addition, in the scope of children, the EU Action Plan on Childhood Obesity 2014-2020 was adopted.⁶⁷⁴

The EU Tobacco control has been focused on a command-and-control approach, whereas the Alcohol Strategy is centered primarily on self-regulation.⁶⁷⁵ In the nutrition scope, the EU has embraced a mix of self-regulation and regulations.⁶⁷⁶ The EU has mostly relied on non-legally binding measures such as pledges, voluntary commitments from the food industry, and “best practices” between Member States.⁶⁷⁷ The limited legislative measures have been focused on “consumer empowerment” to make healthier choices.⁶⁷⁸ In addition, the EU has advocated for a multi-sector approach, thereby creating opportunities for private-sector engagement and the establishment of PPPs.

⁶⁶⁹ World Health Organization, ‘Noncommunicable Diseases in 53 Countries: WHO/Europe Presents New Visual Data Tool’ (*WHO* 2022) <<https://www.who.int/europe/news/item/05-01-2022-noncommunicable-diseases-in-53-countries-who-europe-presents-new-visual-data-tool>> accessed 7 July 2025.

⁶⁷⁰ Garde, ‘The Lack of Coherence in the European Union’s Approach to Noncommunicable Disease Prevention’ (n 653).

⁶⁷¹ *ibid.*

⁶⁷² European Commission, *Green Paper on Promoting Healthy Diets and Physical Activity: A European Dimension for the Prevention of Overweight, Obesity and Chronic Diseases* COM(2005) 637 final.

⁶⁷³ Alemanno and Garde, ‘Chapter 13: European Union’ (653) 260.

⁶⁷⁴ As this thesis is not focused in childhood solely it wont explore further the EU Action Plan on Childhood Obesity.

⁶⁷⁵ Alemanno and Garde, ‘Chapter 1: Regulating Lifestyles: Europe, Tobacco, Alcohol and Unhealthy Diets’ (n 14) 12.

⁶⁷⁶ *ibid.*

⁶⁷⁷ Garde, ‘The Lack of Coherence in the European Union’s Approach to Noncommunicable Disease Prevention’ (n 653).

⁶⁷⁸ *ibid.*

Since this research is focused on the risk factor “unhealthy diets,” it will exclusively analyze the legal measures regarding this factor, including an analysis of food regulation in the European region.⁶⁷⁹

2 Categories of policy interventions to prevent and control NCDs

Eight categories have been identified in which the EU sets policy interventions to prevent and control NCDs.⁶⁸⁰ The first would be disclosure requirements and information schemes, which consist of providing consumers with information that enables them to make an informed choice about their consumption behavior. This method is very common and is considered cheap, easy to enforce, and less restrictive than many other regulatory interventions by policymakers.⁶⁸¹

The second is the regulation of marketing. Marketing restrictions encompass the limitations to the advertising and other forms of promotion (including sponsorship, merchandising, and product placement) of certain products.⁶⁸² For instance, a ban on the marketing of sweetened beverage drinks to children. These constraints would mean restrictions to the ability of economic operators to promote and market their products either to the general public or, as has been more widely employed, to particularly vulnerable segments of the population, notably children. In Europe, the prohibition of marketing HFSS food products to children has primarily been implemented through self-regulation as opposed to the establishment of legally binding norms, as is the case with tobacco products.⁶⁸³

The third category of policy intervention would be measures affecting product availability. Concerning unhealthy diets, the main examples are product reformulation and restrictions imposed on products, such as the limits imposed on portion sizes.⁶⁸⁴ As will be explored next, product reformulation in Europe has been predominantly pursued through a voluntary

⁶⁷⁹ European Commission, Communication on a Farm to Fork Strategy for a fair, healthy and environmentally-friendly food system COM(2021) 44 final <<https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:52020DC0381>> accessed 22 June 2025. It is estimated that in the EU in 2017 over 950,000 deaths (one out of five) and over 16 million lost healthy life years were attributable to unhealthy diets, mainly cardiovascular diseases and cancers.

⁶⁸⁰ Alberto Alemanno and Amandine Garde, ‘Regulating Lifestyles in Europe: How to Prevent and Control Non-Communicable Diseases Associated with Tobacco, Alcohol and Unhealthy Diets?’ (Svenska Institutet För Europapolitiska Studier 2013) <<https://sieps.se/publikationer/2013/regulating-lifestyles-in-europe-how-to-prevent-and-control-non-communicable-diseases-associated-with-tobacco-alcohol-and-unhealthy-diets/>> p. 25, accessed 7 July 2025.

⁶⁸¹ *ibid*, 26.

⁶⁸² *ibid*, 35.

⁶⁸³ *ibid*, 37.

⁶⁸⁴ *ibid*, 40.

approach. It is crucial to highlight that while these measures may initially appear to differ in nature, they nonetheless have a direct impact on the commercial availability of a product and pursue the overarching goal of limiting its overall consumption.⁶⁸⁵

Economic instruments have also been used as strategies for NCD prevention. Through these instruments, public authorities can encourage healthy lifestyles by lowering the price of healthy commodities, such as fruit and vegetables, or discourage unhealthy lifestyles by increasing the price of goods and services linked with unhealthy lifestyles.⁶⁸⁶

Subsidies refer to financial assistance provided to specific goods, such as nutritious foods, intending to reduce their cost (potentially even rendering them free), thereby enhancing their accessibility and, consequently, promoting their consumption.⁶⁸⁷ For instance, the EU has adopted the School Fruit Scheme in the school year of 2009-2010, subsidizing the free distribution of fruit and/or vegetables in schools.⁶⁸⁸

On the other hand, to discourage the consumption of certain products, fiscal measures take the form of taxes imposed on particular substances, such as unhealthy food. This concept of ‘excise taxation’ is rooted in the theories of Arthur Pigou, who advocated for the imposition of special taxes on goods and services whose prices did not accurately reflect the true social cost associated with their consumption. The EU has not adopted any harmonizing legislation on food taxes; however, some Member States have adopted taxes on sugar, salt, and sweetened beverages.⁶⁸⁹

The other categories identified have been a fundamental rights approach, self-regulation, performance-based regulation, and supportive policies, which include education campaigns, research programs, and NCD monitoring and evaluation schemes.⁶⁹⁰

II Closer look at the EU public health strategies focused on unhealthy diets⁶⁹¹

⁶⁸⁵ *ibid*, 41.

⁶⁸⁶ *ibid*, 42.

⁶⁸⁷ *ibid*.

⁶⁸⁸ *ibid*, 43.

⁶⁸⁹ *ibid*, 44.

⁶⁹⁰ *ibid*, 46-57.

⁶⁹¹ This analysis examines the broader dimensions of unhealthy diets under EU public health strategies, without focusing on specific issues such as commercial marketing to children. For a targeted discussion of the topic, see

1 Green Paper on promoting healthy diets and physical activity

In 2005, the EU Commission invited contributions on nutrition and physical activity. The areas for action identified in the Green Paper were consumer information and advertising, consumer education, children and young people, the workplace, the role of health professionals, linkage with other policies, socio-economic inequalities, and a comprehensive and integrated approach.⁶⁹²

A few points are important to highlight concerning the Green Paper. First, regarding consumer information and advertising, it affirms that consumer policy aims to “empower people to make informed choices about their diet,” and it recognizes that clear information about the nutritional content is a key element of this approach.⁶⁹³ Still, in the field of consumer information and advertising, it underscores that self-regulation could be a valid solution and has “a number of advantages over external regulation, mainly in terms of speed and flexibility” and it proposed questions about the effectiveness of self-regulation and what would be the alternatives to be considered in case of failure.⁶⁹⁴

Concerning consumer education, it aimed to identify best practices, including the role of public-private partnerships. The Green Paper consultation found the need for consistency and coherence in Community policies and the importance of a multi-sector approach.⁶⁹⁵

2 The Obesity Prevention White Paper

Subsequently, the Green Paper consultation, the European Commission adopted the Obesity Prevention White Paper in 2007 as a response to the challenge of overweight and obesity in the region.

This strategy is not legally binding and focuses on six priority areas: better-informed consumers, making the healthy option available, encouraging physical activity, developing the evidence base to support policy making, developing monitoring systems, and making children

for example: Amandine Garde, ‘Harmful Commercial Marketing and Children’s Rights: For a Better Use of EU Powers’ (2020) 11 European Journal of Risk Regulation 841.

⁶⁹² EC, *Green Paper on Promoting Healthy Diets and Physical Activity* (n 672).

⁶⁹³ *ibid.*

⁶⁹⁴ *ibid.*

⁶⁹⁵ National Institute for Public Health and the Environment, ‘Report on the Contributions to the Green Paper: “Promoting Healthy Diets and Physical Activity: A European Dimension for the Prevention of Overweight, Obesity and Chronic Diseases”’ (RIVM, 2006).

and young people and low socio-economic groups a priority.⁶⁹⁶ In addition, expresses that the Commission's preference is to keep the existing voluntary approach at the EU level because "it can potentially act quickly and effectively to tackle rising overweight and obesity rates".⁶⁹⁷

It is imperative to observe that the second principle for action established in the Obesity Prevention White Paper enumerates the instruments to be used, which include legislation, networking, public-private approaches, and the engagement of the private sector and civil society.⁶⁹⁸ In addition, calling for efficiency affirms that the strategy will demand actions from various private actors, such as the food industry, being one of its core characteristics is the "partnership approach".⁶⁹⁹

In addition, it encourages food reformulation campaigns.⁷⁰⁰ Finally, it recognizes that "private actors have a major role to play in developing the healthy choice for consumers".⁷⁰¹ The areas enumerated for action by the private actors are: making the healthy option available and affordable, keeping consumers informed, encouraging physical activity, priority groups and settings, and developing a picture of good and best practices.⁷⁰²

A few key points can be highlighted in the White Paper. It prioritizes prevention, primarily through empowering consumers, suggesting that public authorities should support individuals in their attempt to make healthier choices. Nutrition labeling is seen as a crucial method of informing consumers about food composition and facilitating informed decisions, aligning with the approach of "better-informed consumers". Moreover, there is a call for public-private approaches and the inclusion of private actors in the solution.

3 EU Platform on Diet, Physical Activity and Health

In 2005, the EU Platform on Diet, Physical Activity, and Health was created. The Platform is a representative forum that brings together European-level organizations, including food industries, consumer organizations, and public health NGOs, as well as scientific and

⁶⁹⁶ Commission of the European Communities, *White Paper on a Strategy for Europe on Nutrition, Overweight and Obesity related health issues* SEC (2007) 1482 final (Brussels, 2007) p 5-9.

⁶⁹⁷ *ibid*, 6.

⁶⁹⁸ Commission of the European Communities, *White Paper on a Strategy for Europe* (n 696) p 3.

⁶⁹⁹ *ibid*, 4.

⁷⁰⁰ *ibid*, 7.

⁷⁰¹ *ibid*, 10.

⁷⁰² *ibid*, 10-11.

professional associations, to tackle overweight and obesity through voluntary commitments.⁷⁰³ The areas of priority are consumer information (comprehending labelling), education, physical activity promotion, marketing and advertising, and food composition.⁷⁰⁴ It has been identified as a public-private partnership.⁷⁰⁵

In addition to its official members, the EU Platform includes several organizations that hold observer status. These organizations include the World Health Organization, EU Presidencies, the European Parliament, the European Committee of the Regions, the European Economic and Social Committee, Member States, and the European Food Safety Authority.⁷⁰⁶ EU Platform members convened in plenary sessions four times annually and engage in specialized working groups. These working groups are structured around themes that align with the priorities established by the Platform when it was first set up.⁷⁰⁷

The voluntary commitments were aimed at supporting national governments in EU countries in reducing the intake of salt, saturated fat, trans fat, and added sugars; increasing the consumption of fruit and vegetables; reducing the exposure to and impact on children of marketing of foods; increasing regular physical activity and reducing sedentary behavior; increasing the rates of exclusive and continued breastfeeding; and reducing diet and physical activity related inequalities.⁷⁰⁸

The members had to commit to adopting at least one commitment to address unhealthy diets.⁷⁰⁹ By 2010, 292 commitments were made by the EU Platform members.⁷¹⁰ The commitments delineate the specific actions the platform members intend to undertake to contribute towards resolving the issue. In addition, platform members agree to monitor and evaluate the

⁷⁰³ Oliver Bartlett and Amandine Garde, 'Chapter 13: the EU Platform and the EU Forum: New Modes of Governance or a Smokescreen for the Promotion of Conflicts of Interest?' in Alberto Alemanno and Amandine Garde (eds), *Regulating Lifestyle Risks: The EU, Alcohol, Tobacco and Unhealthy Diets* (Cambridge University Press 2015) 284-286. The commitments take place in EU countries, Iceland, Norway and Switzerland.

⁷⁰⁴ *ibid.*

⁷⁰⁵ Arsenios Tselengidis and Per-Olof Östergren, 'Lobbying against Sugar Taxation in the European Union: Analysing the Lobbying Arguments and Tactics of Stakeholders in the Food and Drink Industries' (2018) 47 *Scandinavian Journal of Public Health* 565.

⁷⁰⁶ Bartlett and Garde, 'Chapter 13: the EU Platform and the EU Forum' (n 703) 285.

⁷⁰⁷ *ibid.*

⁷⁰⁸ European Commission, 'EU platform for diet, physical activity and health' (*Health EC*) <https://health.ec.europa.eu/other-pages/basic-page/eu-platform-diet-physical-activity-and-health-database_en> accessed 01 May 2025.

⁷⁰⁹ Garde, 'The Lack of Coherence in the European Union's Approach to Noncommunicable Disease Prevention' (n 653).

⁷¹⁰ Amandine Garde, 'Chapter 2' in Amandine Garde, *EU Law and Obesity Prevention* (Kluwer Law International 2010).

performance of their commitments in a transparent, participative and accountable way, as set out in the Platform’s Monitoring framework”.⁷¹¹

According to the Monitoring Framework, the prescribed minimum criteria for monitoring a commitment are that the commitment’s alignment with the overarching goals of the Platform is explicitly delineated. In addition, each commitment is accompanied by a set of objectives. When feasible, the resources allocated to each commitment are specified (inputs). Finally, the commitment is evaluated, and the attained outcomes are documented and made public (outputs).⁷¹²

In 2014, the annual report that summarizes the activities of the platform showed that 33 commitments were dedicated to education, including lifestyle modification, 26 commitments to advocacy and information exchange, 18 commitments related to composition of foods (reformulation), availability of healthy food options, portion sizes, 14 commitments linked to consumer information, including labeling, 13 commitments to marketing and advertising and 12 commitments physical activity promotion. However, around half of the commitments (63 commitments/54%) had fully implemented the actions planned in the annual objectives for 2014.⁷¹³ Additionally, it has been noted that only a limited number of commitments pertain to the formulation of the products in question, an area where the food and alcohol industries arguably could have the potential to contribute.⁷¹⁴ Instead, most commitments have concentrated on the contexts or ways in which these products are consumed, rather than addressing their underlying formulation.⁷¹⁵

In 2007, as part of the EU Platform, the EU Pledge was launched, an EU-wide voluntary initiative from food and beverage manufacturers to improve commercial communications to children.⁷¹⁶

The EU Platform failed to meet the anticipated standards. The platform members exhibited a notable overrepresentation of industry stakeholders who aimed to leverage their positions to

⁷¹¹ EU Platform on diet, Physical Activity and Health, ‘Monitoring Framework’ <http://ec.europa.eu/health/ph_determinants/life_style/nutrition/platform/docs/eu_platform_monitoring_framework_en.pdf> accessed 18 March 2024. This monitoring is supposed to be updated annually by the members and to be recorded in the Platform database. However, currently this platform database cannot be accessed.

⁷¹² *ibid*, 3.

⁷¹³ European Commission, Directorate-General for Health and Food Safety, *Monitoring the Activities of the EU Platform on Diet, Physical Activity and Health: Annual Report 2015* (2015).

⁷¹⁴ Bartlett and Garde, ‘Chapter 13: the EU Platform and the EU Forum’ (n 703) 304. For this reason, this research does not include these EU platforms as case studies in the sample selection of public-private partnerships for NCD prevention, as the focus of this thesis is specifically on initiatives aimed at food reformulation.

⁷¹⁵ Bartlett and Garde, ‘Chapter 13: the EU Platform and the EU Forum’ (n 703) 304.

⁷¹⁶ Part 2, Chapter 8, III, 2.1 EU Pledge.

change policy-making in the direction of weaker interventions, underlining the power imbalance between private and public members.⁷¹⁷ In 2019, seven civil society organizations resigned from the European Platform for Diet, Physical Activity, and Health after calling for an urgent, profound, and meaningful overhaul to improve the Platform's outcome.⁷¹⁸

In addition, the EU Diet Platform has been defined as a “space for stereotypical industry versus NGO fights, rather than a space promoting genuine communication”.⁷¹⁹ The critics mentioned that meetings of the Platform “were merely an opportunity for industry to ‘tick the corporate social responsibility box’ and be praised for”, with conflict of interest being pointed out as an inherent issue of the platform.⁷²⁰

In 2021, the European Commission Directorate-General for Health and Food Safety decided to discontinue the EU Platform for Action on Diet, Physical Activity and Health stakeholder group physically and virtually.⁷²¹

4 Europe's Beating Cancer Plan

In 2021, the European Commission published the Europe's Beating Cancer Plan (EBCP), reflecting its “political commitment to leave no stone unturned” in the fight against cancer.⁷²² While principally focused on cancer, the EBCP also extends to addressing a broader spectrum of preventable NCDs.⁷²³

Through its prevention pillar, “Saving lives through sustainable cancer prevention”, the Commission highlighted that unhealthy diets and physical inactivity increase the cancer's risk, noting in particular that efforts to address obesity and diabetes must begin in childhood.⁷²⁴ The

⁷¹⁷ Garde, ‘The Lack of Coherence in the European Union's Approach to Noncommunicable Disease Prevention’ (n 653).

⁷¹⁸ European Public Health Alliance, ‘NGOs leave EU Platform on Diet, Physical Activity & Health’ (EPHA 2019) <<https://epha.org/ngos-leave-eu-platform-on-diet-physical-activity-health/>> accessed 6 November 2023.

⁷¹⁹ Charlotte Godziewski, ‘Is “Health in All Policies” Everybody's Responsibility? Discourses of Multistakeholderism and the Lifestyle Drift Phenomenon’ (2020) 15 *Critical Policy Studies* 229.

⁷²⁰ *ibid.*

⁷²¹ European Commission, Directorate-General for Health and Food Safety, *Closure of the EU Platform for Action on Diet, Physical Activity and Health* (SANTE.DDG1.C/JR(2021)5390781, 2021).

⁷²² European Commission, *Communication Europe's Beating Cancer Plan* COM(2021) 44 final <<https://eur-lex.europa.eu/legal-content/en/TXT/?uri=COM:2021:44:FIN>> accessed 22 June 2025.

⁷²³ European Public Health Alliance, ‘EPHA's Review of the Europe's Beating Cancer Plan (EBCP) Implementation’ (EPHA 2024) <[https://epha.org/ephas-review-of-ebcp-implementation/#:~:text=Position%20&%20Policy%20Papers-.EPHA%27s%20Review%20of%20the%20Europe%27s%20Beating%20Cancer%20Plan%20\(EBCP\)%20Implementation,Implementation%20Phases](https://epha.org/ephas-review-of-ebcp-implementation/#:~:text=Position%20&%20Policy%20Papers-.EPHA%27s%20Review%20of%20the%20Europe%27s%20Beating%20Cancer%20Plan%20(EBCP)%20Implementation,Implementation%20Phases)> accessed 22 June 2025.

⁷²⁴ EC, *Communication Europe's Beating Cancer Plan* (n 722).

Plan also recognized the influence of marketing and advertising on consumer choices and identified taxation measures as potential tools to advance health promotion objectives.⁷²⁵

The Commission made a series of commitments to prevent NCDs, including proposals for new legislation on food and alcohol labelling. However, it has been underscored that despite these commitments, no corresponding legislative proposals have been published.⁷²⁶

5 WHO Vienna Declaration on Nutrition and Non-communicable Diseases in the Context of Health 2020

In 2013, European Health Ministers adopted the Vienna Declaration to tackle diet-related, non-communicable diseases.⁷²⁷ It recognizes as priority concerns to the reduction of NCDs the excessive intake of energy, saturated fats and trans fats, free sugars and salt, as well as low consumption of vegetables and fruit.⁷²⁸

It affirms that to create healthy food and drink environments, it is important to reduce the marketing of unhealthy foods to children, promote reformulation and clear labelling, use tools like nutrient profiling to support healthy choices, the use of economic tools and incentives to promote healthy eating, and school fruit/ meal schemes.⁷²⁹

III Cross-sectoral legal dimensions of NCD prevention

1 Agricultural and sustainability policies in the EU and diet-related NCDs

The Common Agricultural Policy

Beyond direct public health strategies, other policy areas significantly impact NCD prevention. As previously mentioned, agricultural policies intersect with the EU's legal competencies

⁷²⁵ *ibid.*

⁷²⁶ Amandine Garde and others, 'Lobbying, Transparency and Trust: Power Imbalances and the Failure to Implement Europe's Beating Cancer Plan' (2025) 51 *The Lancet Regional Health - Europe* 101238.

⁷²⁷ World Health Organization Regional Office for Europe, *Vienna Declaration on Nutrition and Noncommunicable Diseases in the Context of Health 2020* (WHO Europe 2013).

⁷²⁸ *ibid.*, para 7.

⁷²⁹ WHO/Europe, *Vienna Declaration on Nutrition and Noncommunicable Diseases* (n 727) para 12.

related to health and food. The CAP, established under Art. 39 of the TFEU, aims to foster a sustainable and competitive agricultural sector that can support the livelihoods of farmers and provide healthy and sustainable food for society.⁷³⁰ The CAP can impact unhealthy diets, which are a significant factor in the development of non-communicable diseases. For instance, it has been highlighted that by subsidizing milk and beef, CAP policies have historically made foods high in saturated fats more affordable for low-income populations. In contrast, the fruit and vegetable sector has received comparatively little support. This disparity has contributed to socioeconomic inequalities in diet-related diseases, with low-income individuals experiencing higher rates of cardiovascular disease, obesity, and diabetes due to limited access to nutritious foods.⁷³¹ These findings highlight the complex and sometimes conflicting interactions between agricultural policies and public health objectives.

Farm to Fork Strategy

Another point that deserves attention related to sustainability, agriculture, and public health is the “Farm to Fork Strategy.” On 20 May 2020, the EU Commission published the Farm to Fork Strategy, which is part of the European Union’s Green Deal.⁷³² This strategy addresses the challenges of building sustainable food systems and recognizes the inextricable links between healthy people, healthy societies, and a healthy planet.

To advance sustainable food consumption and facilitate the transition to a healthy and sustainable diet, the strategy centers on consumer empowerment, which entails providing clear information to enable consumers to make informed choices regarding their dietary habits. This objective is pursued through the adoption of harmonized mandatory front-of-pack nutrition labeling.⁷³³ In 2023, legal scholars called on the EU Commission to propose legislation

⁷³⁰ European Commission, ‘The Common Agricultural Policy at a Glance: The Common Agricultural Policy Supports Farmers and Ensures Europe’s Food Security’ (*Agriculture European Commission* 2022) <https://agriculture.ec.europa.eu/common-agricultural-policy/cap-overview/cap-glance_en> accessed 3 April 2025.

⁷³¹ James McEldowney, ‘EU Agricultural Policy and Health: Some Historical and Contemporary Issues’ (*European Parliament* 2020) <[https://www.europarl.europa.eu/thinktank/en/document/EPRS_IDA\(2020\)659302](https://www.europarl.europa.eu/thinktank/en/document/EPRS_IDA(2020)659302)> accessed 3 April 2025.

⁷³² EC, ‘Farm to Fork Strategy’ (n 679).

⁷³³ *ibid.*

requiring food to be labeled with Nutri-Score on a mandatory basis across the EU.⁷³⁴ The EU has not yet adopted a harmonized mandatory front-of-pack nutrition labelling.⁷³⁵

The Farm to Fork Strategy refers to food procurement to improve the availability and price of sustainable food and tax incentives, such as targeted rate use to support organic fruit and vegetables.⁷³⁶

The EU Code of Conduct on Responsible Food Business and Marketing Practices entered into force in July 2021. It was one of the first deliverables of the Farm to Fork Strategy and an integral part of its action plan.⁷³⁷ The Code comprises a set of 7 aspirational objectives as voluntary commitments to contribute to a food environment that makes healthy and sustainable food choices easier.

The first aspirational objective is related to promoting food consumption patterns (for healthy and sustainable diets). Aspirational objective 1 is “healthy, balanced and sustainable diets for all European consumers,” with the idea of reversing malnutrition and diet-related NCDs in the EU and reducing the environmental footprint of food consumption by 2030.⁷³⁸

In order to achieve the first objective, two main targets have been developed. First, to improve food consumption patterns in the EU through encouraging the consumption of fruits and vegetables, whole grain cereals, fiber, nuts and pulses, including locally-produced varieties; providing and promoting more sustainably-produced food products/meals; through product reformulation (where feasible) concerning the nutritional composition and environmental footprint of food products/meals; promoting consumer awareness of healthy, balanced and sustainable diets, including sustainable food consumption, as part of healthy & sustainable lifestyles.⁷³⁹

The second target is “a food environment that makes it easier to choose healthy and sustainable diets.” This includes, inter alia, the promotion of transparent, voluntary product information to consumers; responsible food marketing and advertising practices; promoting healthy and

⁷³⁴ Nikhil Gokani and Amandine Garde, ‘Front-of-Pack Nutrition Labelling: Time for the EU to Adopt a Harmonized Scheme’ (2023) 33 *European Journal of Public Health* 751.

⁷³⁵ Last update 25 June 2025.

⁷³⁶ EC, ‘Farm to Fork Strategy’ (n 679) 14-15.

⁷³⁷ European Commission, ‘EU Code of Conduct on Responsible Food Business and Marketing Practices’ (*Food European Commission*) <https://food.ec.europa.eu/horizontal-topics/farm-fork-strategy/sustainable-food-processing/code-conduct_en> accessed 1 April 2024.

⁷³⁸ *ibid.*

⁷³⁹ *ibid.*

sustainable food service practices; and supporting local actions to enhance access to healthy and sustainable diets for all.

As of 31 July 2023, there were 136 signatories of the Code, including industry associations and large enterprises such as Ferrero, Mondelez, Nestlé, Unilever, Coca-Cola, and PepsiCo.⁷⁴⁰ Concerning healthy, balanced and sustainable diets, within the scope of the objective of “healthy, balanced and sustainable diets,” a study on mapping the percentage of signatory companies that have made at least one commitment regarding marketing and advertising revealed that the percentage was very low. Better levels of engagement have been seen in the composition of foods, availability of healthy food options, and portion sizes. Consumer information, including labelling, was not very adherent, but better than marketing commitments. Finally, education, including lifestyle, has a poor perception, besides the manufacture of beverages, which represents 40% of commitment.⁷⁴¹

2 Analysis of the EU nutrition policy through the consumer law and food law lens⁷⁴²

Consumer protection

Consumer protection is an indirect form of tackling NCDs. The legislative framework of EU food policy results from a combination of Treaty provisions that integrate elements from agricultural and internal market regulations, as well as the obligation to ensure a high level of protection of public health and consumers in its policies.⁷⁴³

The EU has placed consumer empowerment at the center of its strategic framework. For instance, the Obesity White Paper, the Farm to Fork Strategy, and Europe’s Beating Cancer Plan highlight the objective of empowering consumers to make informed, healthy food

⁷⁴⁰ *ibid.*

⁷⁴¹ Ipsos, ‘Study on Commitments Pledged under the EU Code of Conduct on Responsible Food Business and Marketing Practices’ (European Commission 2022).

⁷⁴² This section briefly examines the relevance of food information law, particularly health and nutrition claims to unhealthy diets and NCD prevention. For more comprehensive analyses of EU food law and nutrition policy, see, for example: Marine Friant-Perrot and Amandine Garde, ‘From BSE to Obesity: EFSA’s Growing Role in the EU’s Nutrition Policy’ in Alberto Alemanno and Simone Gabbi (eds), *Foundations of EU Food Law and Policy* (Routledge 2014); Caoimhín Macmaoláin, ‘Chapter 8’, *EU Food Law: Protecting Consumers and Health in a Common Market* (Hart Publishing 2007); Hanna Schebesta and Kai Purnhagen, ‘Chapter 6: Nutrition and Health in EU Food Law’, *EU Food Law* (Oxford University Press 2024).

⁷⁴³ Bernd van der Meulen, ‘The Structure of European Food Law’ (2013) 2 *Laws* 69.

choices.⁷⁴⁴ In addition, the EU Consumer Policy Strategy for 2007-2013 stated that “empowered and informed consumers can more easily make changes in lifestyle and consumption patterns contributing to the improvement of their health, more sustainable lifestyles”.⁷⁴⁵

The EU adopts the idea of the “empowered consumer,” which is the “alert” and “circumspect” consumer, meaning that it does not need the public authorities to dictate what shall be the permitted ingredients of products; the consumer can, in reality can be informed and exercise the choice.⁷⁴⁶ A key component of this empowerment is the information paradigm, which assumes that providing consumers with accurate and accessible information is an optimal regulatory strategy that protects all consumers’ interests while imposing little burden on economic operators.⁷⁴⁷

This paradigm is reflected in the regulation of nutritional labeling and the increasing use of front-of-package labeling as a public health tool to guide consumers in making healthier dietary choices. The underlying idea is that if the food information given to the consumer is sufficient, accurate, non-misleading, clear, and easy to understand, the consumer is well-informed and consequently empowered to make healthy food choices.⁷⁴⁸

Food Information Regulation

In this context, a key legislation is the Food Information Regulation.⁷⁴⁹ The Food Information Regulation lays down that food information shall be accurate, clear, and easy to understand for the consumer.⁷⁵⁰ After the adoption of the Farm to Fork Strategy, the European Commission announced a revision of EU rules on the information provided to consumers to introduce harmonized mandatory front-of-pack nutrition labelling.⁷⁵¹

⁷⁴⁴ N Gokani, ‘Healthier Food Choices: From Consumer Information to Consumer Empowerment in EU Law: Journal of Consumer Policy’ (2024) 47 Journal of Consumer Policy 271.

⁷⁴⁵ European Commission, *Communication from the Commission to the Council, the European Parliament and the European Economic and Social Committee – EU Consumer Policy Strategy 2007-2013 – Empowering consumers, enhancing their welfare, effectively protecting them* COM(2007) 99 final.

⁷⁴⁶ Stephen Weatherill, *EU Consumer Law and Policy* (Edward Elgar Publishing 2014) 352 p. 310.

⁷⁴⁷ Vincent Delhomme, ‘Rethinking Consumer Empowerment: New Directions for Sustainable Food Law in an Era of EU Discontent’ (2024) 15 European Journal of Risk Regulation 232.

⁷⁴⁸ Gokani, ‘Healthier Food Choices’ (n 744).

⁷⁴⁹ Regulation (EU) No 1169/2011 of the European Parliament and of the Council of 25 October 2011 on the provision of food information to consumers [2011] OJ L304/18

⁷⁵⁰ *ibid*, art 7(2).

⁷⁵¹ European Commission, ‘Proposal for a Regulation on the Provision of Food Information to Consumers (Revision of Regulation FIC)’ (*Food European Commission*) <<https://food.ec.europa.eu/food-safety/labelling->

The information paradigm seeks to enhance transparency by supplying consumers with relevant information. Thus, consumers are protected by imposing obligations on businesses to disclose the characteristics of their goods and services.⁷⁵² However, this approach reflects the idea of “individual autonomy” and that consumers must take primary responsibility for their consumption choices.⁷⁵³

One criticism of the Food Information Regulation is that it leaves nutrition information to be provided voluntarily by industry.⁷⁵⁴

Food Claim Regulation

In addition, the Food Claim Regulation (Regulation 1924/2006) regulates the nutrition claims and health claims that are made on food labelling. The Food Claim Regulation has been described as a “cornerstone of EU nutrition policy”.⁷⁵⁵ The nutritional claim refers to “any claim which states, suggests or implies that a food has particular beneficial nutritional properties due to: (a) the energy (calorific value) it (i) provides, (ii) provides at a reduced or increased rate, or (iii) does not provide; and/or (b) the nutrients or other substances it”.⁷⁵⁶ Whereas health claim means “any claim that states, suggests or implies that a relationship exists between a food category, a food or one of its constituents and health;”⁷⁵⁷ Nutrition and health claims shall not be false, ambiguous or misleading, give rise to doubt about the safety and/or the nutritional adequacy of other foods.⁷⁵⁸

It has been underscored that nutrition claims might be seen as an encouragement to food manufacturers to reformulate their products and place more nutritious foods on the market.⁷⁵⁹ However, these claims can be seen as a powerful marketing tool for food industry operators.⁷⁶⁰

and-nutrition/food-information-consumers-legislation/proposal-revision-regulation-fic_en> accessed 22 June 2025. No final decision has yet been taken on this proposal.

⁷⁵² Garde, ‘The Lack of Coherence in the European Union’s Approach to Noncommunicable Disease Prevention’ (n 653).

⁷⁵³ *ibid.*

⁷⁵⁴ *ibid.*

⁷⁵⁵ Garde and others, ‘Lobbying, Transparency and Trust’ (n 726).

⁷⁵⁶ Regulation (EC) No 1924/2006 of the European Parliament and of the Council of 20 December 2006 on nutrition and health claims made on foods [2006] OJ L404/9, ch I art 4.

⁷⁵⁷ *ibid.*, ch I art 5.

⁷⁵⁸ *ibid.*, ch II art 3.

⁷⁵⁹ M Friant-Perrot and A Garde, ‘From BSE to Obesity – EFSA’s Growing Role in the EU’s Nutrition Policy’ in A Alemanno and S Gabbi, *Foundations of EU Food Law and Policy: Ten Years of the European Food Safety* (Abingdon, Routledge 2014), p 139.

⁷⁶⁰ *ibid.*

Thus, the regulatory measures existing concerning nutrition and health claims are essential to ensure that these claims are reliable, inform consumer choices, and prevent misleading information.⁷⁶¹

⁷⁶¹ *ibid.*

CHAPTER 7: DOMESTIC LEVEL

I Preliminary remarks

According to GOSTIN, protecting the public's health is necessarily a public function that should also be regarded as a duty of government.⁷⁶² At the domestic level, one avenue for legal intervention in NCD prevention is through traditional regulatory instruments, such as command-and-control measures. For instance, the adoption of taxation or bans on advertising and promoting unhealthy products. Additionally, a new trend to be observed is the adoption of mandatory front-of-package labelling.⁷⁶³

This section will present a selection of public health legal tools for NCD prevention, highlighting how these measures vary across jurisdictions through illustrative examples from different countries.⁷⁶⁴ The legal tools to be presented here are in line with GOSTIN's taxonomy of regulatory measures in the context of public health law. In particular, concerning unhealthy diets, the measures to be explored are taxation, measures relating to marketing, and packaging and labelling measures.⁷⁶⁵

II Legal tools

1 Taxation

1.1 Public health taxes

It is known that price has a significant influence on consumption.⁷⁶⁶ Health taxes are taxes imposed on goods or services that cause consumers to pay higher prices, and therefore,

⁷⁶² Lawrence O Gostin, 'Law and Ethics in Population Health' (2004) 28 *Australian and New Zealand Journal of Public Health* 7.

⁷⁶³ See Part 2, Chapter 7, II, 3 Mandatory front-of-package labelling.

⁷⁶⁴ While the focus is not on an exhaustive examination of each example provided, the objective is to demonstrate the diversity of public health regulatory responses to NCDs across countries.

⁷⁶⁵ Measures related to food production and manufacturing are not examined in detail here, as reformulation efforts have primarily taken the form of voluntary initiatives. These will be addressed more fully in the section on PPPs for NCD prevention. This analysis instead concentrates on state-adopted measures within the command-and-control spectrum.

⁷⁶⁶ OT Mytton, D Clarke and M Rayner, 'Taxing Unhealthy Food and Drinks to Improve Health' (2012) 344 *BMJ* 2931.

taxpayers adjust their behavior to avoid the tax.⁷⁶⁷ Whereas the primary idea of health taxes lies in their capacity to discourage the consumption of unhealthy products through price increases, it has also been observed that health taxes result in product reformulation.⁷⁶⁸ In addition, in some cases, revenue generation has the potential to designate funds for health-promoting purposes.⁷⁶⁹

Two distinct categories of taxes exist: direct taxes and indirect taxes. Direct taxes are imposed on the incomes of individuals or companies, whereas indirect taxes are applied to the production or acquisition of goods and services.⁷⁷⁰ Public health taxes, which predominantly encompass consumption taxes, are commonly referred to as indirect taxes. While governments collect indirect taxes from producers and distributors, such taxes are usually passed on to consumers in the form of higher prices to induce changes in the consumption of the taxed products. The main categories of consumption tax are sales taxes/value-added taxes (VAT), import duties, and excise taxes on select goods and services.⁷⁷¹

The preferred category for “public health taxes” is the excise taxes on select goods and services. Excise taxes are a category of consumption taxes that target specific products to increase their price relative to other consumer goods.⁷⁷² From an economic perspective, government-mandated excise taxes are put in place to correct market failures (externalities).⁷⁷³ Mostly used as “Pigovian taxes” that represent a fiscal strategy designed to promote significant societal goals by influencing individual behavior.⁷⁷⁴ This taxation model systematically considers the adverse externalities generated by consumption behaviors, thereby compelling taxpayers to internalize the comprehensive costs associated with their actions, encompassing those costs not directly borne by them.⁷⁷⁵

⁷⁶⁷ World Health Organization, *Fiscal Policies for Diet and Prevention of Noncommunicable Diseases: Technical Meeting Report, 5-6 May 2015, Geneva, Switzerland* (2015) (WHO 2016).

⁷⁶⁸ Sarah A Roache and Lawrence O Gostin, ‘The Untapped Power of Soda Taxes: Incentivizing Consumers, Generating Revenue, and Altering Corporate Behavior’ (2017) 6 *International Journal of Health Policy and Management* 489.

⁷⁶⁹ WHO, *Fiscal Policies for Diet and Prevention of Noncommunicable Diseases* (n 767).

⁷⁷⁰ World Health Organization, *WHO Manual on Sugar-Sweetened Beverage Taxation Policies to Promote Healthy Diets* (Geneva, 2022) 48.

⁷⁷¹ *ibid.*

⁷⁷² WHO, *Fiscal Policies for Diet and Prevention of Noncommunicable Diseases* (n 767).

⁷⁷³ In this case, these negative externalities are the financial costs of NCDs and lost productivity associated with diet-related NCDs.

⁷⁷⁴ WHO, *WHO Manual on Sugar-Sweetened Beverage Taxation* (n 770) 50.

⁷⁷⁵ Rachele Holmes Perkins, ‘Salience and Sin: Designing Taxes in the New Sin Era’ [2014] *Brigham Young University Law Review* 143.

Tobacco taxes have been implemented in many countries and have resulted in a substantial reduction in smoking rates.⁷⁷⁶ Recently, the so-called “sin taxes” have also been applied to sugar, junk food, and sweetened drinks.⁷⁷⁷

In the context of unhealthy food, this idea highlights information failures, how much consumers understand the long-term health impacts of their choices, and the failure to consider external costs (for the health care system and workplace).⁷⁷⁸

In 2011, Denmark was the first country to introduce a “fat tax” aimed at mitigating cardiovascular disease.⁷⁷⁹ This tax system was structured to target saturated fat content in foods. However, less than 12 months after its implementation, the Danish government opted to repeal the tax. This decision was primarily influenced by the population’s ability to circumvent the controversial fiscal measure. Citizens resorted to purchasing taxed items from neighboring countries such as Germany or Sweden, thereby undermining the intended impact of the tax within Danish borders.⁷⁸⁰ In addition, there was a big influence of the food industry, which lobbied against the tax.⁷⁸¹

A critical consideration pertains to the categorization of taxes, specifically in discerning between taxes targeting specific nutrients and those applied to predetermined food and beverage categories. The challenge lies in the nuanced nature of taxing nutrients, where, for instance, imposing a tax on fat may lead to disproportionately high taxes on nuts, despite their high-fat content; nuts are not unhealthy products.⁷⁸² This has been seen in the example of Denmark.

1.2 Sugar-sweetened beverages taxes

A recent trend has been the adoption of SSB taxes to promote public health.⁷⁸³ Soda taxes originally had the purpose of generating revenue.⁷⁸⁴ In 1994, a new strategy was proposed in the US: to use the funds collected from taxes on junk food to support physical activity or

⁷⁷⁶ Gostin and Wiley, *Public Health Law: Power, Duty, Restraint* (n 353) 461.

⁷⁷⁷ Mytton, Clarke and Rayner, ‘Taxing Unhealthy Food and Drinks to Improve Health’ (n 766).

⁷⁷⁸ Caroline Franck, Sonia M Grandi and Mark J Eisenberg, ‘Taxing Junk Food to Counter Obesity’ (2013) 103 *American Journal of Public Health*.

⁷⁷⁹ *ibid.*

⁷⁸⁰ *ibid.*

⁷⁸¹ Malene Bødker and others, ‘The Rise and Fall of the World’s First Fat Tax’ (2015) 119 *Health Policy* 737.

⁷⁸² Franck, Grandi and Eisenberg, ‘Taxing Junk Food to Counter Obesity’ (n 788).

⁷⁸³ The consumption of SSBs has been one of the main contributors of unhealthy diets and the associated NCDs. SSBs have no nutritional benefits and are a primary source of free sugars which increase overall energy intake and may reduce the intake of foods containing more nutritionally beneficial calories.

⁷⁸⁴ Marion Nestle, *Soda Politics: Taking on Big Soda (and Winning)* (Oxford University Press 2017) 363.

nutrition education to fight against obesity raising numbers.⁷⁸⁵ Later, in 2009, it was proposed to impose high levels of taxes in order to discourage consumption.⁷⁸⁶

According to the WHO, as of July 2022, at least 108 countries worldwide apply national-level excise taxes to at least one type of SSB.⁷⁸⁷ A sugar-sweetened beverage encompasses any drink with caloric sweeteners, including carbonated soft drinks, sports drinks, energy drinks, fruit drinks, chocolate (or otherwise sweetened) milk, and sweetened coffee and tea. However, this classification excludes beverages consisting solely of 100 percent fruit juice or diet beverages substituted with noncaloric sweeteners.⁷⁸⁸ In most cases, the model of tax levied on SSBs has been the consumption tax, which can differ from general consumption taxes (e.g., value-added taxes, sales taxes) to specific consumption taxes (e.g., excise taxes).⁷⁸⁹ Countries have different approaches to defining taxable products.

For example, in 2012, France implemented a tax on sweetened soft drinks (Law No. 2011-1977).⁷⁹⁰ This tax applied to all non-alcoholic beverages containing added sugar (e.g., sodas, fruit juice) or sweeteners (e.g., diet drinks), and was paid by manufacturers and processors in France and by French importers.⁷⁹¹ Studies indicated that the implementation of the 2012 tax resulted in a modest reduction in the consumption of sugar-sweetened beverages, averaging less than 5%.⁷⁹² The design of this tax was considered problematic; for instance, its scope was not based solely on a nutritional criterion (it also covered artificially sweetened drinks).⁷⁹³

Subsequently, in 2018, a revised taxation framework was introduced in France. This new tax on SSBs is directly linked to the quantity of added sugars present in the beverage. Unlike its predecessor, the 2018 soda tax demonstrates a more explicit commitment to public health objectives by aligning with sugar content. The primary objective of this tax is to influence consumer behavior by elevating prices, thereby discouraging the purchase of SSBs.

⁷⁸⁵ *ibid.*

⁷⁸⁶ *ibid.*

⁷⁸⁷ World Health Organization, 'Global Report on the Use of Sugar-Sweetened Beverage Taxes' (WHO 2023).

⁷⁸⁸ Hunt Allcott, Benjamin B Lockwood and Dmitry Taubinsky, 'Should We Tax Sugar-Sweetened Beverages? An Overview of Theory and Evidence' (2019) 33 *Journal of Economic Perspectives* 202.

⁷⁸⁹ Courtney Baltz, 'TaxRx: Ultra-Processed Foods, Added Sugar, and the Social Cost of Obesity' (2020) 75 *Food and Drug Law Journal* 596 <<https://www.jstor.org/stable/27007750>> accessed 5 March 2024.

⁷⁹⁰ Sara Capacci and others, 'The Impact of the French Soda Tax on Prices and Purchases. An Ex Post Evaluation' (2019) 14 *PLoS ONE*.

⁷⁹¹ *ibid.*

⁷⁹² Yann Le Bodo and others, 'Public Health Lessons from the French 2012 Soda Tax and Insights on the Modifications Enacted in 2018' (2022) 126 *Health Policy*.

⁷⁹³ *ibid.*

Simultaneously, it aims to incentivize manufacturers to reformulate their products to reduce added sugar content.⁷⁹⁴

An additional primary example is the case of Mexico. In January 2014, Mexico introduced an excise tax of 1 peso per liter, equating to approximately a 10% price increase, on all non-alcoholic beverages containing added sugar, whether in powder form, concentrates, or ready-to-drink varieties.⁷⁹⁵ This policy initiative was aimed at mitigating the adverse effects of SSB consumption on rates of overweight and obesity, as well as the consequent direct and indirect economic burdens.⁷⁹⁶

A study published in 2017 revealed a notable decline in purchases of taxed beverages, amounting to a reduction of 5.5% in 2014 and 9.7% in 2015, resulting in an average reduction of 7.6% over the study period.⁷⁹⁷ Notably, households with lower socioeconomic status exhibited the principal decreases in taxed beverage purchases during both years. Conversely, purchases of untaxed beverages saw a modest increase of 2.1% during the study period.⁷⁹⁸

In addition, the same study contradicted industry assertions suggesting a diminishing effectiveness of the tax after its initial year of implementation. On the contrary, the findings demonstrated a greater reduction in SSB purchases in 2015 compared to 2014.⁷⁹⁹ This reduction was particularly higher among households with lower socioeconomic status, both in absolute terms.⁸⁰⁰

Finally, the reduction in SSB consumption in Mexico suggests that the tax on sugary beverages could prevent nearly 190,000 new cases of diabetes over a decade, resulting in an average savings of approximately Int\$983 million (equivalent to roughly £785 million) in related healthcare costs.⁸⁰¹

⁷⁹⁴ *ibid.*

⁷⁹⁵ WHO, *Fiscal Policies for Diet and Prevention of Noncommunicable Diseases* (n 767).

⁷⁹⁶ M Cochero and others, 'In Mexico, Evidence of Sustained Consumer Response Two Years after Implementing a Sugar-Sweetened Beverage Tax' (2017) 36 *Health Affairs* <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1231?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed> accessed 10 April 2024.

⁷⁹⁷ *ibid.*

⁷⁹⁸ *ibid.*

⁷⁹⁹ *ibid.*

⁸⁰⁰ *ibid.*

⁸⁰¹ The Lancet Diabetes & Endocrinology, 'Sweet Success: Will Sugar Taxes Improve Health?' (2017) 5 *The Lancet Diabetes & Endocrinology* 235.

As mentioned above, other countries adopted SSB taxation, for instance, South Africa, the UK, Portugal, Chile, and a few states in the US.⁸⁰²

1.3 Future directions for public health taxes

In 2023, Colombia was the first country to introduce a health tax targeting ultra-processed foods.⁸⁰³ The “junk food law” will impose a gradual tax on sugary drinks and ultra-processed foods, meaning that in 2023 there will be a 10% tax, then 15% in 2024, before reaching 20% in 2025.⁸⁰⁴

From an economic perspective, it has been remarked that variations in food prices due to taxes have minimal impact on consumer behavior because food demand is considered inelastic.⁸⁰⁵ Given the essential nature of food to human life, consumer demand remains relatively stable despite price fluctuations. However, research has shown that consumers are more responsive to price changes in processed foods compared to whole foods.⁸⁰⁶ Despite this, the indispensable nature of food suggests that even changes in processed food prices are unlikely to reduce consumption significantly. Nonetheless, even minor changes in purchasing patterns due to the implementation of a food tax can help mitigate obesity-related risks and significantly impact individual health.⁸⁰⁷ Moreover, public health taxes on unhealthy foods can encourage manufacturers to reformulate their products, such as by reducing sugar content, to align with healthier standards.

Finally, beyond the challenges exemplified in the Danish case, one of the primary concerns regarding the taxation of unhealthy products is the argument that it negatively affects lower socioeconomic groups, as obesity rates more heavily impact these groups.⁸⁰⁸ This argument of taxes being “regressive” is employed mainly by the industry and has proved not to be true.⁸⁰⁹

⁸⁰² Obesity Evidence Hub, ‘Countries That Have Implemented Taxes on Sugar-Sweetened Beverages (SSBs)’ (Obesity Evidence Hub 2024) <<https://www.obesityevidencehub.org.au/collections/prevention/countries-that-have-implemented-taxes-on-sugar-sweetened-beverages-ssbs>> accessed 15 April 2024.

⁸⁰³ Weronika Strzyżyńska, ‘Colombia Passes Ambitious “Junk Food Law” to Tackle Lifestyle Diseases’ (*The Guardian* 2023) <<https://www.theguardian.com/global-development/2023/nov/10/colombia-junk-food-tax-improve-health-acc>> accessed 15 April 2024.

⁸⁰⁴ Camilo Sánchez, ‘The Most Ambitious “Health Tax” in Latin America Debuts in Colombia’ (*El País* 2023) <<https://english.elpais.com/international/2023-11-01/the-most-ambitious-health-tax-in-latin-america-debuts-in-colombia.html>> accessed 15 April 2024.

⁸⁰⁵ Baltz, ‘TaxRx: Ultra-Processed Foods, Added Sugar, and the Social Cost of Obesity’ (n 789).

⁸⁰⁶ *ibid.*

⁸⁰⁷ *ibid.*

⁸⁰⁸ *ibid.*

⁸⁰⁹ Daniel R Taber and others, ‘Society of Behavioral Medicine (SBM) Position Statement: Enact Taxes on Sugar Sweetened Beverages to Prevent Chronic Disease’ (2018) 9 *Translational Behavioral Medicine* 179.

In addition, echoing arguments previously used by the tobacco industry to oppose tobacco taxes, the food industry argues that such taxes would prove ineffective, unjust, and detrimental to the industry, potentially resulting in job losses.⁸¹⁰

2 Marketing restrictions of unhealthy products

A second considered command-and-control approach, falling within the scope of the government's power to alter the information environment, is the imposition of marketing restrictions on certain products.⁸¹¹ Once again, such restrictions or bans on advertising are frequently seen in the context of tobacco products.⁸¹² Nevertheless, the food industry has historically escaped comparable regulation.⁸¹³ Recently, a growing number of jurisdictions have begun to adopt legal measures restricting the marketing of unhealthy food products, particularly those targeting children.

Marketing restrictions have been defined as “limitations to the advertising and other forms of promotion (including sponsorship, merchandizing, and product placement) of certain products.”⁸¹⁴ These restrictions aim to restrict the ability of economic operators to promote and market their products either to the general public or to certain groups of the population.⁸¹⁵

The impact of aggressive marketing of unhealthy foods through advertisements on children's overconsumption of junk food and the subsequent rise in childhood overweight and obesity has been well-established.⁸¹⁶ Children are considered more vulnerable to marketing strategies than adults because they do not fully grasp advertisements' intent.⁸¹⁷ Advertising for unhealthy foods appears across various forms of media, including television, newspapers, the internet, social media, and even video games.⁸¹⁸

⁸¹⁰ Mytton, Clarke and Rayner, 'Taxing Unhealthy Food and Drinks to Improve Health' (n 766).

⁸¹¹ Gostin and Wiley, *Public Health Law: Power, Duty, Restraint* (n 353) 452-453.

⁸¹² WHO Framework Convention on Tobacco Control (n 31) art 13.

⁸¹³ Gostin, *Global Health Law* (n 3) 399.

⁸¹⁴ Amandine Garde and Marine Friant-Perrot, 'Chapter 4: The Regulation of Marketing Practices for Tobacco, Alcoholic Beverages and Foods High in Fat, Sugar and Salt – a Highly Fragmented Landscape' in Alberto Alemanno and Amandine Garde (eds), *Regulating Lifestyle Risks: The EU, Alcohol, Tobacco and Unhealthy Diets* (Cambridge University Press 2015) 69.

⁸¹⁵ *ibid.*

⁸¹⁶ Y Kovic and others, 'The Impact of Junk Food Marketing Regulations on Food Sales: An Ecological Study' (2018) 19 *Obesity Reviews* 761.

⁸¹⁷ *ibid.*

⁸¹⁸ Gostin, *Global Health Law* (n 3) 399.

In 2010, the WHO adopted the “Set of Recommendations on the marketing of foods and non-alcoholic beverages to children,” urging countries to regulate food and beverage marketing for products high in saturated fats, trans-fatty acids, sugars, and/or salt to children.⁸¹⁹ Despite receiving endorsement from 192 member states, many countries, particularly in Europe, have opted for industry self-regulation when implementing these recommendations at the domestic level.⁸²⁰ Again in 2023, the WHO released a new guideline on policies to protect children from the harmful impact of food marketing, recommending that nations adopt stronger and mandatory policies to protect children from the harmful impact of food marketing.”⁸²¹

In Latin America, several countries adopted regulations to restrict food and beverage marketing to children. These regulations can be categorized into three groups: those prohibiting any marketing of unhealthy products to children, those restricting marketing to specific media or times, and those imposing mild restrictions on food and beverage marketing targeted at children.⁸²²

For instance, Chile has enacted a comprehensive ban on advertising food and drinks high in saturated fat, added sugars, and sodium to children under 14.⁸²³ The law applies across all forms of media and also limits the use of commercial tactics, such as children’s characters and games, to promote these products.⁸²⁴

In Peru, advertising ultra-processed foods is prohibited from employing techniques that exploit children’s naivety. Marketing strategies are also banned from offering prizes, gifts, or utilizing children’s characters to promote product acquisition.⁸²⁵

Mexico is one example of a partial limitation of the marketing of food and beverages. In 2014, the country adopted a regulation limiting the marketing of certain food and nonalcoholic beverages high in sodium, fat, or sugar via television and cinemas. Regarding television, the regulations prohibit advertising during designated children’s viewing times. For cinemas,

⁸¹⁹ World Health Organization, *Set of Recommendations on the Marketing of Foods and Non-Alcoholic Beverages to Children* WHA63.14 (2010).

⁸²⁰ See Part 2, Chapter 8, III Self-regulation.

⁸²¹ World Health Organization, *Policies to Protect Children from the Harmful Impact of Food Marketing* (2023).

⁸²² Diana Guarnizo-Peralta, ‘Marketing Ultra-Processed Food and Beverages to Children in Latin America: Business Responsibilities and State Duties’ (2022) 7 *Business and Human Rights Journal* 418.

⁸²³ Ley 20606 sobre Composición Nutricional de los Alimentos y su Publicidad (promulgated 6 June 2012, last amended by Ley 21362, 18 August 2021) Ministerio de Salud (Chile).

⁸²⁴ Guarnizo-Peralta, ‘Marketing Ultra-Processed Food and Beverages to Children in Latin America’ (n 822).

⁸²⁵ Ley N° 30021, Ley de Promoción de la Alimentación Saludable para Niños, Niñas y Adolescentes (promulgated 17 May 2013) Congreso de la República del Perú. Tiene Como Objetivo la Implementación de Quioscos y Comedores Saludables y el Fomento de la Actividad Física en Las Instituciones de Educación Básica Regular.

advertisements for these products are prohibited during screenings of films targeting families and general audiences.⁸²⁶

Moreover, the UK has limited the advertising of unhealthy food to children since 2007 and recently passed a law banning ads on television for junk food products between 5:30 a.m. and 9 p.m.⁸²⁷

In conclusion, marketing restrictions on unhealthy foods seek to foster changes in dietary behaviors by reducing direct exposure to such products, thereby indirectly enhancing food environments.⁸²⁸ While the importance of mandatory policies to restrict the marketing of unhealthy foods to children has been widely acknowledged, a 2023 UNICEF survey revealed that only 11 out of 24 countries surveyed had implemented legal measures to address children's exposure to unhealthy food marketing. This is despite over two-thirds of respondents recognizing food marketing as a significant issue and deeming industry self-regulation insufficient.⁸²⁹

3 Mandatory front-of-package labelling

Packaging and labelling played a prominent role in the tobacco case. Given the focus of this research on food products, it aims to delve into public policies regarding food labelling, particularly emphasizing front-of-package labelling.⁸³⁰ This regulatory strategy aims to promote healthier dietary habits. It falls within the government's power to alter the information environment.⁸³¹

Front-of-package labelling has been defined as “the provision of nutrition information in the principal field of vision on food and drinks packaging”.⁸³² Given that the nutrition information traditionally located on the back of the packaging has shown limited efficacy in aiding

⁸²⁶ Guarnizo-Peralta, ‘Marketing Ultra-Processed Food and Beverages to Children in Latin America’ (n 822).

⁸²⁷ Department of Health and Social Care, NHS England and The Rt Hon Wes Streeting MP, ‘Junk Food Ad Ban Legislation Progresses to Curb Childhood Obesity’ (*Gov UK 2021*) <www.gov.uk/government/news/junk-food-ad-ban-legislation-progresses-to-curb-childhood-obesity> accessed 14 February 2025.

⁸²⁸ The last updated concerning the status of adoption of Bans/restrictions on advertising and promoting unhealthy products is from February 2025.

⁸²⁹ UN Children's Fund, *Key Barriers to Food Marketing Regulation: Global Survey Results of 24 Countries* (UNICEF 2023).

⁸³⁰ It's essential to emphasize that in certain countries, for example most countries in Europe, front-of-package (FoP) labeling has been implemented voluntarily. This section will solely focus on illustrating examples mostly from Latin America where FoP labeling is adopted in a mandatory nature.

⁸³¹ Gostin and Wiley, *Public Health Law: Power, Duty, Restraint* (n 353) 446.

⁸³² Vincent Delhomme, ‘Front-of-Pack Nutrition Labelling in the European Union: A Behavioural, Legal and Political Analysis’ (2021) 12 *European Journal of Risk Regulation* 825.

consumers in understanding the relative healthfulness of packaged food, jurisdictions have been adopting different types of FOP nutrition labels.⁸³³ Moreover, FOP systems have shown an increase in the use and understanding of nutrition labelling compared to traditional nutrient fact panels.⁸³⁴

Front-of-package labeling can be either reductive, merely restating the details found in the nutrition facts panel typically located on the back of packages, or interpretive, offering an assessment of a food's nutritional quality. The latter provides additional, easily accessible information, particularly beneficial for individuals with lower health literacy levels.⁸³⁵

Nowadays, there are different types of FOP systems around the globe. Multiple Traffic Lights (United Kingdom), the Nutri-Score (France, Belgium, Germany, Spain, The Netherlands, Luxembourg, Switzerland), Warning Labels (Chile, Mexico, Israel, Uruguay, Peru), and the Health Star Rating system (Australia, New Zealand). Endorsement logos (e.g., the Nordic Keyhole (Northern Europe), Choices Programme (Czech Republic, Nigeria), and Healthier Choice Symbol (Singapore)).⁸³⁶ The FOP labeling can be adopted on a voluntary or mandatory basis.

In 2016, Chile was the first country to implement a mandatory national front-of-package nutrient warning label policy.⁸³⁷ The FOP labelling adopted in Chile is the warning labels system represented by black octagons with the words “high in” sugar, sodium, saturated fat, and/or calories.⁸³⁸ The implementation of mandatory warning labels similar to the one in Chile can be seen in countries such as Uruguay, Peru, Brazil, Mexico, and Israel.⁸³⁹

In 2020, Mexico adopted a compulsory front-of-package labelling regulation with warning labels on the front of food packages that contain “excess” sugar, calories, sodium, or saturated fat.⁸⁴⁰ Under this regulation, products with one or more warning labels are not allowed to

⁸³³ Anne Marie Thow and others, ‘Global Governance of Front-of-Pack Nutrition Labelling: A Qualitative Analysis’ (2019) 11 *Nutrients* 268.

⁸³⁴ Marcela Reyes and others, ‘Development of the Chilean Front-of-Package Food Warning Label’ (2019) 19 *BMC Public Health*.

⁸³⁵ Simone Pettigrew and others, ‘An 18-Country Analysis of the Effectiveness of Five Front-of-Pack Nutrition Labels’ (2023) 104 *Food Quality and Preference* 104691.

⁸³⁶ *ibid.*

⁸³⁷ Marcela Reyes and others, ‘Changes in the Amount of Nutrient of Packaged Foods and Beverages after the Initial Implementation of the Chilean Law of Food Labelling and Advertising: A Nonexperimental Prospective Study’ (2020) 17 *PLOS Medicine*.

⁸³⁸ *ibid.*

⁸³⁹ Reyes and others, ‘Development of the Chilean Front-of-Package Food Warning Label’ (n 834).

⁸⁴⁰ Eric Crosbie and others, ‘Implementing Front-of-Pack Nutrition Warning Labels in Mexico: Important Lessons for Low- and Middle-Income Countries’ (2023) 26 *Public Health Nutrition* 2149.

include children’s characters, cartoons, celebrities, athletes, pets, or interactive elements (such as visual-spatial or downloadable games) that may incite or promote the products’ consumption.⁸⁴¹ This aspect of prohibiting children’s characters, cartoons, etc., had a significant impact on marketing.⁸⁴²

FOP labelling has been identified as a strategic approach to enhance consumer information at the point of purchase, thereby fostering healthier food choices.⁸⁴³ In addition, it encourages companies to reformulate their products.

A recent study examining changes in Chile’s packaged food supply following the implementation of the country’s mandatory FOP warning label law found widespread product reformulation aimed at reducing sugar, sodium, saturated fat, and calorie content. As a result, the proportion of foods and beverages in Chilean stores requiring a “high in” nutrient warning label decreased from 71% in 2015–2016, before the law’s enactment, to 53% by 2020, following the implementation of its third and most stringent phase.⁸⁴⁴ In Mexico, a recent study also found that there has been an improvement in the nutritional profile of the packaged food and beverage supply after the warning-label implementation.⁸⁴⁵

On the other hand, systems like Nutri-Score remain voluntary in Europe. Similarly, the labeling of Australia’s Health Star Rating system and the United Kingdom’s Multiple Traffic Lights is not mandatory.⁸⁴⁶

III Case study: Switzerland

⁸⁴¹ Norma Oficial Mexicana NOM-051-SCFI/SSA1-2010, *Especificaciones generales de etiquetado para alimentos y bebidas no alcohólicas preenvasados-Información comercial y sanitaria*, published 5 April 2010, section 4.1.5(a).

⁸⁴² Guarnizo-Peralta, ‘Marketing Ultra-Processed Food and Beverages to Children in Latin America’ (n 822).

⁸⁴³ Reyes and others, ‘Development of the Chilean Front-of-Package Food Warning Label’ (n 834).

⁸⁴⁴ Natalia Rebolledo and others, ‘Changes in the Critical Nutrient Content of Packaged Foods and Beverages after the Full Implementation of the Chilean Food Labelling and Advertising Law: A Repeated Cross-Sectional Study’ (2025) 23 BMC Medicine.

⁸⁴⁵ Juan Carlos Salgado and others, ‘Product Reformulation in Non-Alcoholic Beverages and Foods after the Implementation of Front-of-Pack Warning Labels in Mexico’ (2025) 22 PLoS Medicine.

⁸⁴⁶ Global Food Research Program at UNC-Chapel Hill, ‘Front-of-Package Labeling Policies Around the World’ (*Global Food Research Program* 2024) <<https://www.globalfoodresearchprogram.org/resource/front-of-package-label-maps/>> accessed 10 April 2025.

1 Legal competences

Federalism

In Switzerland, the protection of public health falls within the scope of Art. 118 of the Federal Constitution.⁸⁴⁷ Paragraph 1 of this provision sets clear boundaries on the legal competence of the Swiss Confederation, which may only regulate matters explicitly assigned to it by the Constitution. The Confederation intervenes primarily when the cantons are either unable to act effectively or when uniform regulation across the country is deemed necessary.⁸⁴⁸

Paragraph 2 specifies several areas where the Confederation holds regulatory authority. These include, under letter (a), the regulation of foodstuffs, therapeutic products, narcotics, organisms, chemical substances, and objects that may pose health risks. Under letter (b), to prevent and control communicable diseases, widespread illnesses, and particularly dangerous diseases affecting both humans and animals.⁸⁴⁹ In these domains, the federal legislator has what has been termed “fragmentary” legislative power.⁸⁵⁰ The adoption of the Federal Act on Foodstuffs is an example of this legal competence in practice.⁸⁵¹

Additionally, the Confederation shares responsibilities with the cantons in broader health-related policy areas. For example, Art. 41(1) of the Constitution sets out social objectives that both levels of government must strive to achieve, in support of personal responsibility and private initiative. These include ensuring access to necessary healthcare for all individuals (letter b), and promoting the well-being, social integration, and healthy development of children and young people (letter g).⁸⁵² The cantons, in addition to exercising their powers in the field of health are also tasked with the execution of federal legislation.⁸⁵³

In Switzerland, the Federal Food Safety and Veterinary Office (FSVO) is responsible for measures related to unhealthy diets and nutrition. These include approaches to reducing salt and sugar, front-of-package labelling schemes, and marketing unhealthy food to children.⁸⁵⁴ At the

⁸⁴⁷ *Federal Constitution of the Swiss Confederation* (18 April 1999) art 118.

⁸⁴⁸ Peter-Spiess, *Food Regulation and Public Health* (n 16) 53.

⁸⁴⁹ *Federal Constitution of the Swiss Confederation* (18 April 1999) 53 art 118.

⁸⁵⁰ Peter-Spiess, *Food Regulation and Public Health* (n 16) 53-54.

⁸⁵¹ *ibid.*

⁸⁵² *ibid.*, 60.

⁸⁵³ *ibid.*, 62.

⁸⁵⁴ Office Fédéral de la Sécurité Alimentaire et des Affaires Vétérinaires, *Aliments et nutrition* <<https://www.blv.admin.ch/blv/fr/home/lebensmittel-und-ernaehrung/ernaehrung.html>> accessed 10 April 2025.

same time, the Federal Office of Public Health is responsible for the National Strategy for the Prevention of Non-communicable Diseases by the FOPH.⁸⁵⁵

The Federal Act on Foodstuffs

The Federal Act on Foodstuffs establishes a legal framework aimed at ensuring food safety, protecting consumers from deception, and enabling informed dietary choices.⁸⁵⁶ Here, “foodstuffs” are broadly defined as all substances or products, whether processed, partly processed, or unprocessed, that are intended or may reasonably be expected to be consumed by humans. This includes not only conventional foods but also substances intentionally added during production, as well as drinks and chewing gum.⁸⁵⁷

The Foodstuffs Act aims to protect consumer health by ensuring that foodstuffs and utility articles are handled hygienically, by preventing consumer deception, and by guaranteeing that consumers receive the information necessary to make informed purchasing decisions.⁸⁵⁸ Through its provisions and implementing ordinances, the Federal Act on Foodstuffs imposes legal requirements in key areas such as hygiene, safety, and labelling.⁸⁵⁹

Its comprehensive scope allows it to cover a wide range of products that contribute to dietary patterns and are relevant in the context of NCD prevention. However, there are a few legal provisions in practice that specifically address unhealthy products, which could be related to NCD prevention. In 2024, Art. 22 of the Federal Ordinance of the FDHA on Information on Foodstuffs was amended to require that nutrition declarations include the sugar content of such products.⁸⁶⁰ Previously, most food products were only required to declare energy value along with fats, carbohydrates, proteins, and salt, without specifying sugar content.⁸⁶¹ Additionally, a revision of the Foodstuffs Act concerning the marketing of unhealthy products aimed at children was expected to be presented in the fall of 2024.⁸⁶²

⁸⁵⁵ Peter-Spiess, *Food Regulation and Public Health* (n 16) 257.

⁸⁵⁶ *ibid.*, 31.

⁸⁵⁷ Federal Act on Foodstuffs and Utility Articles of 20 June 2014 (Foodstuffs Act, FSA; CC 817.0) art 4.

⁸⁵⁸ Peter-Spiess, *Food Regulation and Public Health* (n 16) 31.

⁸⁵⁹ *ibid.*

⁸⁶⁰ Peter-Spiess, *Food Regulation and Public Health* (n 16) 36.

⁸⁶¹ *ibid.*

⁸⁶² *ibid.* However to this date there has been no adoption of any legal provision concerning the marketing of unhealthy products aimed at children. Last consultation 23 June 2025.

Regulatory failure in NCD prevention

In 2012, an attempt to pass a “Draft Federal Act on Health Prevention and Promotion” was rejected by the Swiss Federal Parliament.⁸⁶³ The draft legislation aimed to strengthen the national framework for disease prevention, health promotion, and early detection measures, thereby addressing the existing legislative gap in the prevention of NCDs.⁸⁶⁴

However, rather than concentrating on the content of the bill, parliamentary discussions shifted toward a broader ideological debate, emphasizing tensions between State and individual responsibility.⁸⁶⁵ The outcome reflected a strong skepticism toward government involvement in public health matters and a strong influence of the tobacco and food industries.⁸⁶⁶ As a result, Switzerland opted for a voluntary approach in its efforts to tackle non-communicable diseases and unhealthy diets.

2 Soft law initiatives

In 2013, the Swiss Federal Council endorsed a comprehensive healthcare strategy named “Health 2020,” which prioritizes health promotion and disease prevention.⁸⁶⁷ Later in 2016, it was established the “National Strategy for the Prevention of Non-Communicable Diseases” which aims to reduce behavioral risk factors; improve health literacy; develop a health-promoting environment; enhance equity in access to health promotion and prevention; reduce the proportion of the population at increased risk of disease; improve the quality of life and reduce the need for care.⁸⁶⁸ The strategy has four overarching long-term goals: “reduce the disease burden; control rising costs; reduce premature mortality; maintain and enhance the social participation and productivity of the entire population.”⁸⁶⁹

⁸⁶³ Thomas Mattig, *L'échec de la loi sur la prévention: un enseignement* (Document de travail 9, Promotion Santé Suisse, Lausanne et Berne 2013).

⁸⁶⁴ Peter-Spiess, *Food Regulation and Public Health* (n 16) 51.

⁸⁶⁵ Mattig, *L'échec de la loi sur la prévention: un enseignement* (n 863).

⁸⁶⁶ Julia Salomé Richter, ‘The Role of Soft Law in the Prevention and Control of Non-Communicable Diseases’ [2020] *Völkerrechtsblog* <<https://voelkerrechtsblog.org/de/the-role-of-soft-law-in-the-prevention-and-control-of-non-communicable-diseases/>> accessed 10 April 2025.

⁸⁶⁷ Federal Office of Public Health, *The Federal Council's health policy strategy 2020–2030* <<https://www.bag.admin.ch/en/the-federal-councils-health-policy-strategy-20202030>> accessed 22 April 2024.

⁸⁶⁸ Federal Office of Public Health (FOPH) and Swiss Conference of the Cantonal Ministers of Public Health (CMPH), *The Challenge of Non-Communicable Diseases: National Strategy on the Prevention of Non-Communicable Diseases 2017–2024 (NCD Strategy), Short Version, Extended to 2028* (ed Nicole Fivaz and Christoph Hoigné, FOPH April 2016).

⁸⁶⁹ *ibid.*

It has been observed that the effective implementation of the National Strategy in Switzerland faces challenges, primarily due to the significant role played by the 26 Swiss cantons. The cantons possess a considerable degree of autonomy in health matters and exhibit distinct characteristics, influenced by factors such as their population size or financial capacities.⁸⁷⁰

In the context of unhealthy diets, the “Swiss Nutrition Policy 2017-2024” was elaborated under the National Strategy. This strategy encompasses three main goals: increasing nutritional competencies, improving the framework conditions, and integrating the food industry.⁸⁷¹

Nutri-Score

As part of the Swiss Nutrition Policy 2017-2024, Switzerland adopted the front-of-package labelling system Nutri-Score in 2019.⁸⁷² In Switzerland, it is estimated that 70 producers and retailers have committed to adopting the Nutri-Score. This initiative covers 168 brands and over 6,000 products with front-of-package labelling.⁸⁷³

Upon the introduction of Nutri-Score, there was a motion asking for front-of-package labelling to be mandatory on industrial product packaging. The Federal Council rejected the obligation to be enshrined in law and decided to adopt the Nutri-Score voluntarily.⁸⁷⁴ Within the framework of the foodstuff’s legislation in Switzerland, the Nutri-Score is considered optional information.⁸⁷⁵ Recently, a few issues concerning the Nutri-Score and failure to take into account certain elements (degree of processing, additives, or sustainability) have arisen.⁸⁷⁶ On this occasion, the Federal Council reaffirmed that the Nutri-Score is not a nutritional recommendation but an information tool to help consumers make an informed choice.⁸⁷⁷

⁸⁷⁰ Thomas Mattig and Philippe Chastonay, ‘Switzerland’s National Non-Communicable Diseases Strategy’ (2017) 2 Remedy Publications 1002.

⁸⁷¹ Office Fédéral de la Sécurité Alimentaire et des Affaires Vétérinaires, *Le Conseil fédéral publie un rapport sur l’efficacité du Nutri-Score*, 2 décembre 2022 <<https://www.blv.admin.ch/blv/fr/home/dokumentation/nsb-news-list.msg-id-92042.html>> accessed 24 April 2024.

⁸⁷² *ibid.*

⁸⁷³ *ibid.*

⁸⁷⁴ Swiss Federal Assembly, *Motion 19.3401: Pour l’obligation du label Nutri-Score sur les emballages et dans les publicités des produits industriels*, Conseil national (22 March 2019).

⁸⁷⁵ Ordinance of the FDHA on Foodstuffs Information (OIDAI, RS 817.022.16) art 39.

⁸⁷⁶ Swiss Federal Assembly, *Motion 23.3018: Mettre un terme à l’emploi problématique du Nutri-score*, Conseil des États (21 February 2023).

⁸⁷⁷ *ibid.*

Reformulation

Concerning sugar reduction, Switzerland adopted a voluntary approach through the Declaration of Milan.⁸⁷⁸ Few cantons (such as Geneva and Neuchâtel) have attempted to implement taxes on sugar-sweetened beverages, but these were rejected. Lobbying in Switzerland is understood to have been a significant factor contributing to the failure of these measures and the adoption of voluntary approaches instead.⁸⁷⁹

Different from the agreement on sugar reduction, there is no agreement on reduced salt content in Switzerland. In the scope of salt reduction, in 2008, the FSVO launched the Salt Strategy to encourage the public to reduce salt consumption voluntarily.⁸⁸⁰ In conjunction with industry, FSVO is aiming for a gradual reduction in the amount of salt in products such as bread, meat products, and cheese. At the same time, the general public has been made aware of the problem and given a sense of responsibility. By 2016, the aim was to gradually reduce salt consumption to less than 8g per person per day.⁸⁸¹

Marketing restrictions for children

Finally, concerning the marketing and advertising aimed at children for foods high in sugar, salt, or fat, Switzerland adopted the “Swiss Pledge” in 2010.⁸⁸² Swiss Pledge is a voluntary initiative and a commitment by the food and beverage industry and catering companies that aims to restrict the advertising of foods high in energy, saturated fatty acids, trans-fatty acids, sugars, and salt to children under the age of 12.⁸⁸³

The minimum criteria of the approach are limiting product advertising to children “only products that meet specific criteria based on internationally recognized nutritional recommendations and/or national and international nutritional guidelines may continue to be

⁸⁷⁸ More detailed analysis in Chapter 10, II, 5.

⁸⁷⁹ Nina Schretr, ‘La taxe sur les boissons sucrées a fait ses preuves au niveau scientifique’ (*Heidi News* 2023) <www.heidi.news/alimentation/la-taxe-sur-les-boissons-sucreees-a-fait-ses-preuves-au-niveau-scientifique> accessed 15 February 2023.

⁸⁸⁰ Office fédéral de la sécurité alimentaire et des affaires vétérinaires, Pascale Mühlemann, *Rapport sur la mise en place de mesures visant une réduction de la consommation de sel en Suisse* (Mühlemann Nutrition GmbH, 2019).

⁸⁸¹ Office Fédéral de la Sécurité Alimentaire et des Affaires Vétérinaires, *Réduction du sel* <<https://www.blv.admin.ch/blv/fr/home/lebensmittel-und-ernaehrung/ernaehrung/produktzusammensetzung/salzstrategie.html>> accessed 22 April 2024.

⁸⁸² Swiss Pledge, ‘About Us’ (*Swiss Pledge*) <<https://swiss-pledge.ch/apropos-de-nous/>> accessed 22 April 2024.

⁸⁸³ EU Pledge and Swiss Pledge, *Critères nutritionnels - White paper* (2019).

advertised.”⁸⁸⁴ And no product-specific advertising in elementary school, except for educational purposes, on request or with the express agreement of the school management.⁸⁸⁵ It has been observed that the “added sugar content” is not a criteria to decide if the product can be advertised or not. As a result, the Swiss Pledge model is considered less strict than the criteria imposed by the WHO for food marketing.⁸⁸⁶ Another issue is that it was the companies themselves who set the criteria and monitored the measures.⁸⁸⁷

On 3 May 2023, a motion, titled “in favor of a framework on food marketing targeting children,” was filed.⁸⁸⁸ It urged the Federal Council to introduce a binding and harmonized legal framework, covering all potential advertising platforms, to restrict the advertising of products high in sugar, fat, or salt aimed at children. The Federal Council, in its opinion, underscored that it had favored voluntary measures in the field and it recognized that measures must be strict to be effective. However, nearly a decade of discussions with the food industry on marketing targeted at children has failed to reach an agreement on the criteria. Moreover, as a revision of the Foodstuffs Act was undergoing, which would include the assessment of a draft regulation on marketing targeting children for products with high salt, fat, or sugar contents, the Federal Council proposed to reject the motion.⁸⁸⁹

3 Legal exceptionalism for public health law

In conclusion, the Swiss initiatives to address NCDs linked to unhealthy diets have largely relied on nonbinding measures. Swiss authorities mostly rely on voluntary industry initiatives such as the Declaration of Milan, the Swiss Pledge, and the voluntary adoption of Nutri-Score. This line of action is also reflected in the NCD prevention strategies adopted at the national level, such as Health2020, followed by Health2030, the Swiss Nutrition Policy, and the Swiss National Strategy on the Prevention of NCDs.

Switzerland presents a notable example of legal exceptionalism in the realm of unhealthy diets, where command-and-control regulation has been largely absent. This preference for voluntary

⁸⁸⁴ Swiss Pledge, ‘About Us’ (n 882).

⁸⁸⁵ Swiss Pledge, ‘Engagement’ (*Swiss Pledge*) <<https://swiss-pledge.ch/engagement/>> accessed 23 April 2024.

⁸⁸⁶ Sophie Bucher Della Torre and Corinne Jotterand Chaparro, *Rapport sur la mise en place de mesures visant une réduction de la consommation de sucre* (Haute École de Santé, HES-SO, Genève 2019).

⁸⁸⁷ *ibid.*

⁸⁸⁸ Sophie Michaud Gigon, *Motion 23.3532 “Pour un encadrement du marketing alimentaire destiné aux enfants”* (3 May 2023).

⁸⁸⁹ *ibid.*

measures can be attributed in part to a political culture that is traditionally cautious toward legislative interventions in the field of NCD prevention.⁸⁹⁰ Moreover, it has been highlighted that the fragmented nature of Swiss health policies is shaped by federalism, which attributes many competencies to the cantons.⁸⁹¹ Additionally, the active involvement of private actors in the design and implementation of public health initiatives also contributes to the entrenchment of voluntary approaches.⁸⁹²

Finally, it is noteworthy that the Federal Office of Public Health and the Federal Food Safety and Veterinary Office are involved in measures related to unhealthy diets and NCDs. It has been pointed out that the multiple actors in play can lead to a loss of efficiency in the measures adopted.⁸⁹³

⁸⁹⁰ Richter, 'The Role of Soft Law in the Prevention and Control of Non-Communicable Diseases' (n 866).

⁸⁹¹ *ibid.*

⁸⁹² *ibid.*

⁸⁹³ Peter-Spiess, *Food Regulation and Public Health* (n 16) 257.

CHAPTER 8: PRIVATE RESPONSES

I Preliminary remarks

The perceived shortcomings of the traditional command-and-control approach have given rise to the concept of “new governance,” which has been described as “a seismic reorientation in both the public policymaking process and the tools employed in policy implementation.”⁸⁹⁴

This theory extends beyond a purely state-driven approach to include a wide array of actors who shape social and economic outcomes, acknowledging the influential roles of businesses, consumers, communities, nonprofit organizations, academia, and the media.⁸⁹⁵ New governance departs from characteristics such as rigidity, state-centrism, hierarchical structures, excessive reliance on bureaucratic expertise, and intrusive regulation, it aspires to be more open-textured, participatory, bottom-up, consensus-oriented, contextual, flexible, integrative, and pragmatic.⁸⁹⁶

Command-and-control regulations concerning the NCD risk factors (unhealthy diets) have not been widely adopted. At the EU level, there has been a strong emphasis on individual responsibility, often favoring voluntary measures over binding regulation. At the domestic level, stricter regulatory interventions have frequently been criticized as paternalistic and overly protective of consumers, undermining individual autonomy.

The critique of paternalism has not only constrained the adoption of more robust state-led interventions but also, under the idea of “new governance,” paved the way for private-sector responses. These include purely private initiatives, such as corporate social responsibility and self-regulations, as well as more collaborative models like public-private partnerships for NCD prevention.

II The prevention state and paternalism critique

Policies aimed at safeguarding public health often become entangled in the delicate balance between principles of individual freedoms, juxtaposed with social goals and collective

⁸⁹⁴ Gostin and Wiley, *Public Health Law: Power, Duty, Restraint* (n 353) 207.

⁸⁹⁵ *ibid.*

⁸⁹⁶ *ibid.*

interests.⁸⁹⁷ Consequently, regulations aimed at reducing unhealthy food consumption are frequently characterized as “paternalistic approaches” criticized for infringing upon personal autonomy and individuality. Critics argue that individuals should possess the autonomy to make their own dietary choices without government interference.⁸⁹⁸

DWORKIN defines paternalism as “interference with a person’s liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests, or values of the person being coerced.”⁸⁹⁹ Paternalism is also understood as “a law or policy that intervenes to an individual’s benefit yet against her will.”⁹⁰⁰ Within this definition, three key elements of paternalism have been identified: an action that intentionally constrains an individual’s liberty or autonomy, implemented without their consent, with the objective of either protecting them from harm or providing a benefit otherwise unavailable to them.⁹⁰¹ In summary, for an intervention to be considered paternalistic, it is not merely sufficient to restrain freedom without consent, it must be implemented with the specific intent of assisting the individual subjected to such restrictions.⁹⁰²

Within the scholarly discourse, a distinction is made between two forms of paternalism: soft paternalism and hard paternalism.⁹⁰³ In sum, soft paternalism attempts to address cognitive biases through the presentation of more information to improve the quality of decision-making, but not eliminate completely the choice.⁹⁰⁴ On the other hand, hard paternalism involves direct prohibitions or bans, reflecting a more assertive approach to limiting individual autonomy.⁹⁰⁵ Thus, soft paternalism “protects autonomy by ensuring that the subject’s choices reflect their

⁸⁹⁷ Roger S Magnusson, ‘Mapping the Scope and Opportunities for Public Health Law in Liberal Democracies’ (2007) 35 *Journal of Law, Medicine & Ethics* 571.

⁸⁹⁸ Lawrence O Gostin, ‘Bloomberg’s Health Legacy: Urban Innovator or Meddling Nanny?’ (2013) 43 *Hastings Center Report* 19.

⁸⁹⁹ Gerald Dworkin, ‘Paternalism’ (1972) 56 *The Monist* 64.

⁹⁰⁰ Jessica L Roberts and Elizabeth Weeks Leonard, ‘What Is (and Isn’t) Healthism’ (2016) 50 *Georgia Law Review* 833.

⁹⁰¹ *ibid.*

⁹⁰² *ibid.*; Fernando D Simões, ‘Paternalism and Health Law: Legal Promotion of a Healthy Lifestyle’ (2013) 4 *European Journal of Risk Regulation* 347.

⁹⁰³ See Thaddeus Mason Pope, ‘Counting the Dragon’s Teeth and Claws: The Definition of Hard Paternalism’ (2004) 20 *Georgia Law Review* 659; Wendy E Parmet, ‘Beyond Paternalism: Rethinking the Limits of Public Health Law’ (2014) 46 *Connecticut Law Review*; David Adam Friedman, ‘Public Health Regulation and the Limits of Paternalism’ (2013) 46 *Connecticut Law Review* 1687; Additionally, advancements have been made in distinguishing between weak and strong paternalism, as well as the concept of “libertarian paternalism”, predominantly advocated by Richard Thaler and Cass Sunstein, along with the integration of behavioral economics into public health law. However, delving deeper into the intricacies of paternalism falls outside the scope of this research. The primary focus here is to present criticisms of paternalism, which have contributed to the establishment of PPPs.

⁹⁰⁴ Thaddeus Mason Pope, ‘Limiting Liberty to Prevent Obesity: Justifiability of Strong Hard Paternalism in Public Health Regulation’ (2014) 46 *Connecticut Law Review* 279.

⁹⁰⁵ Parmet, ‘Beyond Paternalism: Rethinking the Limits of Public Health Law’ (n 903).

true preferences”, and in contrast, hard paternalism “may impose actions the agent would not want even if aware of the facts.”⁹⁰⁶

One of the criticisms against paternalism is grounded in MILL’s harm principle. Under the harm principle, “the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant”.⁹⁰⁷ This liberal perspective asserts an intrinsic value in allowing individuals to make their own decisions, even if they opt for choices deemed “unhealthy” from an objective standpoint.⁹⁰⁸

However, as GOSTIN puts “third-party harms are not imaginary”.⁹⁰⁹ The externalities resulting from the overconsumption of unhealthy foods and the high prevalence of NCDs impose negative repercussions on third parties, manifesting as increased social healthcare costs and diminished productivity.⁹¹⁰ Consequently, laws that may seem, from an individualistic standpoint, to regulate an individual’s behavior for their own benefit often appear, from a public health perspective, to be aimed at regulating behavior for the collective good.⁹¹¹

Additionally, as THOMAS and GOSTIN have argued, such antipaternalistic objections rest on a fundamentally flawed premise, the notion that the existing status quo, despite increasing rates of NCDs, is simply the result of individual choices freely made. In reality, “myriad collective decisions” by governments and private actors profoundly shape the options available to individuals, for example, they determine the price and availability of nutritious foods, among others.⁹¹²

1 The nanny state and personal responsibility

Furthermore, paternalism is often portrayed as a negative characteristic.⁹¹³ One commonly employed critique is the use of the term “nanny state”, suggesting that the government treats adults as children by limiting their autonomy and curbing their ability to make independent

⁹⁰⁶ *ibid.*

⁹⁰⁷ John Stuart Mill, *On Liberty* (J W Parker and Son 1859).

⁹⁰⁸ Oliver Bartlett, ‘Power, Policy Ideas and Paternalism in Non-Communicable Disease Prevention’ (2018) 24 *European Law Journal* 474.

⁹⁰⁹ Gostin, ‘Bloomberg’s Health Legacy’ (n 898).

⁹¹⁰ Gostin, *Global Health Law* (n 3) 393.

⁹¹¹ Bartlett, ‘Power, Policy Ideas and Paternalism in Non-Communicable Disease Prevention’ (n 908).

⁹¹² Thomas and Gostin, ‘Tackling the Global NCD Crisis’ (n 29).

⁹¹³ Lawrence O Gostin and KG Gostin, ‘A Broader Liberty: J.S. Mill, Paternalism and the Public’s Health’ (2009) 123 *Public Health* 214.

decisions.⁹¹⁴ For instance, the famous caricature of the mayor of New York City, Michael Bloomberg, being called “Nanny Bloomberg” for instituting a trans-fat ban and trying to limit the container sizes of sugar-sweetened beverages with the “portion cap initiative”.⁹¹⁵

This critique often emphasizes the importance of “personal responsibility”, asserting that individuals should be accountable for their own choices and actions regarding dietary habits.⁹¹⁶ As it has been noted, former UK Prime Minister Tony Blair’s 2006 remarks on health problems illustrate this idea.⁹¹⁷ He argued that issues like obesity, smoking, alcohol abuse, diabetes, and sexually transmitted diseases are “not, strictly speaking, public health problems at all,” but rather “questions of individual lifestyle... not epidemics in the epidemiological sense, they are the result of millions of individual decisions, at millions of points in time.”⁹¹⁸

The “nanny state” argument and the emphasis on personal responsibility have been backed up heavily by the industry.⁹¹⁹ This term was first employed by the tobacco industry and has now been used by the ultra-processed food and SSB industries.⁹²⁰

In this context, a central critique of paternalistic interventions is that they limit fundamental rights and freedoms. Thus, this approach emphasizes that in the realm of unhealthy diets, the focus should be directed toward individual responses rather than collective approaches.⁹²¹

Central to this discussion is the concept of “personal responsibility”, which is delineated as the conviction that individuals should be self-sufficient rather than reliant on governmental support, and in the belief that individuals are inherently autonomous, uninfluenced, and equipped to navigate the challenges of their surroundings.⁹²² Essentially, it posits that individuals bear the responsibility for their own health outcomes.⁹²³ However, the social determinants of health demonstrate that this notion is profoundly shaped, and often constrained, by structural factors beyond individual control.⁹²⁴ Moreover, the recognition of the commercial determinants of

⁹¹⁴ Roberts and Leonard, ‘What Is (and Isn’t) Healthism’ (n 900).

⁹¹⁵ Friedman, ‘Public Health Regulation and the Limits of Paternalism’ (n 903).

⁹¹⁶ Lindsay F Wiley, Micah L Berman and Doug Blanke, ‘Who’s Your Nanny? Choice, Paternalism and Public Health in the Age of Personal Responsibility’ (2013) 41 *The Journal of Law, Medicine & Ethics* 88.

⁹¹⁷ Sara Glasgow and Ted Schrecker, ‘The Double Burden of Neoliberalism? Noncommunicable Disease Policies and the Global Political Economy of Risk’ (2015) 34 *Health & Place* 279.

⁹¹⁸ *ibid.*

⁹¹⁹ Wiley, Berman and Blanke, ‘Who’s Your Nanny?’ (n 916).

⁹²⁰ M Daube, J Stafford and L Bond, ‘No Need for Nanny’ (2008) 17 *Tobacco Control* 426.

⁹²¹ Richard A Epstein, ‘What (Not) to Do about Obesity: A Moderate Aristotelian Answer’ (2025) 93 *Chicago Unbound* 1361.

⁹²² Magnusson, ‘Case Studies in Nanny State Name-Calling’ (n 17).

⁹²³ Gostin and Wiley, *Public Health Law: Power, Duty, Restraint* (n 353) 296.

⁹²⁴ See Part 1, Chapter 1, II NCD risk distribution and social determinants of health.

health is growing, in that in reality, the choices are not that “free” from the influence of the industry.⁹²⁵ Framing obesity and unhealthy diets as personal choice issues has been a strategy applied by the ultra-processed food industries and sweetened sugar beverage industries to shift the focus away from their unhealthy products.⁹²⁶

The notion of individual responsibility has been interpreted as a neoliberal redefinition of citizenship.⁹²⁷ Critics pointed out that embracing individualized, risk-focused approaches to NCD prevention risks deepening neoliberal patterns, ultimately legitimizing them and this can add another layer of personal responsibility to existing social and economic health disparities, disproportionately burdening those with the least control over their lives.⁹²⁸

In conclusion, there is a growing recognition that the pejorative framing of paternalism through the “nanny state” argument, along with an emphasis on personal responsibility, is a tactic used by industry to continue producing unhealthy products freely.⁹²⁹ Businesses frame individuals’ “irresponsible choices” as the main driver of NCDs, shifting the focus to individual-level interventions.⁹³⁰ Furthermore, the critique of paternalistic approaches in public health has facilitated the development of industry-initiated responses, such as self-regulation and corporate social responsibility. This critique has also fostered the emergence of collaborations between the ultra-processed food and sweetened beverage industries and public authorities in the format of PPPs for NCD prevention.

2 Industry tactics against NCD regulation: invoking human rights

It has been identified that human rights have been used to advocate for and attack the regulation of tobacco, alcohol, and unhealthy foods.⁹³¹ The human rights approach to adopting legislation for NCD prevention is grounded on the right to health.⁹³² However, industry actors have

⁹²⁵ See Part 1, Chapter 2, II, 3 Commercial determinants of health.

⁹²⁶ Deborah Morrison Thomson, ‘Big Food and the Body Politics of Personal Responsibility’ (2009) 74 *Southern Communication Journal* 2.

⁹²⁷ Glasgow and Schrecker, ‘The Double Burden of Neoliberalism?’ (n 917).

⁹²⁸ *ibid.*

⁹²⁹ Magnusson, ‘Case Studies in Nanny State Name-Calling’ (n 17).

⁹³⁰ WHO Europe, ‘Commercial Determinants of Noncommunicable Diseases in the WHO European Region’ (n 327); Kaare R. Norum, ‘World Health Organization’s Global Strategy on Diet, Physical Activity and Health: The Process behind the Scenes’ (2005) 49 *Scandinavian Journal of Nutrition* 83.

⁹³¹ Tanya E Baytor and Oscar A Cabrera, ‘Chapter 4: International Human Rights Law’ in Tania Voon, Andrew Mitchell and Jonathan Liberman, *Regulating Tobacco, Alcohol and Unhealthy Foods: the Legal Issues* (Routledge 2014).

⁹³² See Part 2, Chapter 4, III, 1.

strategically mobilized fundamental rights to challenge and resist such regulations, such as freedom of speech, private property, and economic and personal freedom.⁹³³

This legal strategy has long been employed by the tobacco industry, which has invoked rights-based arguments to contest advertising bans, plain packaging laws, and sales restrictions.⁹³⁴ More recently, major food corporations have adopted similar tactics to oppose the implementation of mandatory FOPL policies. By framing these public health measures as violations of commercial free speech and economic liberty, they seek to shift the legal and political discourse away from public health concerns and toward the protection of corporate interests.⁹³⁵

At the individual level, human rights arguments are also invoked in opposition to regulatory interventions, often based on the principle of personal autonomy.⁹³⁶ The notion that individuals should be free to make their own dietary choices, without State interference, has been used to characterize public health policies as paternalistic or coercive. However, it is well-established in research on eating behavior that such choices are not entirely free or independent but rather are influenced by powerful environmental factors.⁹³⁷

Additionally, recent studies on the commercial determinants of health highlight how the aggressive marketing of unhealthy foods (sugary drinks, processed snacks, fast food) drives overconsumption.⁹³⁸ Unhealthy foods are often cheaper and more accessible, especially in low-income or rural areas where access to fresh, healthy options is limited. Moreover, the food industry's lobbying efforts frequently undermine regulations on marketing, labeling, and pricing.⁹³⁹ These dynamics reinforce systemic conditions that restrict "free and independent" choices and perpetuate poor nutrition, obesity, and health inequities. In reality, individuals are not making choices in a vacuum; their options are heavily shaped and often constrained by these external factors.⁹⁴⁰

⁹³³ Toebes and Patterson, 'Human Rights and Non-Communicable Diseases' (n 38) 251.

⁹³⁴ Oscar A Cabrera and Lawrence O Gostin, 'Human Rights and the Framework Convention on Tobacco Control: Mutually Reinforcing Systems' (2011) 7 *International Journal of Law in Context* 285.

⁹³⁵ Campbell, 'Chile: Front-of-Package Warning Labels and Food Marketing' (n 504).

⁹³⁶ James E Katz, 'Individual Rights Advocacy in Tobacco Control Policies: An Assessment and Recommendation' (2005) 14 *Tobacco Control*.

⁹³⁷ Kelly D Brownell and others, 'Personal Responsibility and Obesity: A Constructive Approach to a Controversial Issue' (2010) 29 *Health Affairs* 379.

⁹³⁸ Kalra, Verma and Kapoor, 'Commercial Determinants of Health' (n 349).

⁹³⁹ *ibid*.

⁹⁴⁰ Andrés Constantin, Martín Hevia and Oscar A Cabrera, 'Commercial Speech and Unhealthy Food Products: Conceptual Foundations' (2022) 50 *Journal of Law, Medicine & Ethics* 216.

Therefore, a critical human rights approach requires a nuanced analysis of how rights are invoked and by whom. Human rights can serve as powerful tools to advance public health and prevent NCDs, their instrumentalization by industry actors raises essential questions about the balance between corporate freedoms and public health imperatives. Limitations on individual rights to protect public health have to be proportionate.⁹⁴¹ This includes an assessment if the measures taken to achieve public health are necessary, proportional, and reasonable.⁹⁴² States must show that the proposed limitation is necessary to achieve the public health objective, employs the least restrictive means available, and is proportionate to the benefit gained.⁹⁴³ In the case of adopting regulation to NCD prevention, such limitations have already been justified by the significant public health threat posed by NCDs.⁹⁴⁴

III Self-regulation

1 Definition

Self-regulation has been defined as the “regulatory process that an industry-level organization sets rules and standards relating to the conduct of firms in the industry.”⁹⁴⁵ Essentially, this entails the commitment of an entire industry, rather than individual firms, to adhere to specific rules or standards that they have established to address negative externalities, thereby engaging in a form of self-governance.⁹⁴⁶ The industry sets, enforces, and maintains these rules and standards to ensure ethical behavior among its members, contrasting with governmental intervention, where public agencies establish and enforce regulatory frameworks.⁹⁴⁷

It is crucial to underline that self-regulation and government regulation are not mutually exclusive but have been identified to exist on a continuum.⁹⁴⁸ In contrast to government-imposed regulations, self-regulation is voluntary and is often framed as a socially responsible

⁹⁴¹ Tobin and Barrett, ‘Chapter 3: the Right to Health and Health-Related Human Rights’ (n 417) 68.

⁹⁴² Ibid.

⁹⁴³ Toebes and Patterson, ‘Human Rights and Non-Communicable Diseases’ (n 38) 251.

⁹⁴⁴ See for example restrictions on smoking in public places Toebes and Patterson, ‘Human Rights and Non-Communicable Diseases’ (n 38) 251 and measures targeting sugar overconsumption Peter-Spiess, *Food Regulation and Public Health* (n 16) 96-105.

⁹⁴⁵ Lisa L Sharma, Stephen P Teret and Kelly D Brownell, ‘The Food Industry and Self-Regulation: Standards to Promote Success and to Avoid Public Health Failures’ (2010) 100 *American Journal of Public Health* 240.

⁹⁴⁶ Jan Sammeck, *A New Institutional Economics Perspective on Industry Self-Regulation* (Gabler Verlag 2012) 1-7.

⁹⁴⁷ Ibid.

⁹⁴⁸ Sharma, Teret and Brownell, ‘The Food Industry and Self-Regulation’ (n 945).

industry practice with consumer welfare as its central focus.⁹⁴⁹ In addition, self-regulation is based on the idea that corporations are not only the source of the problem, but they can also be the solution.⁹⁵⁰

This research understands that self-regulation is the “voluntary pledges, commitments, standards, codes of practice or other rule-setting initiatives that companies or industries have created and pledged to follow”.⁹⁵¹ Notably, self-regulation is exclusively initiated and managed by industry stakeholders, not involving public authorities in its development or monitoring process. Therefore, this distinction is crucial for delineating self-regulation from public-private partnerships.

The presented advantages of self-regulation encompass higher flexibility, responsiveness to market dynamics, and lower costs. Moreover, given the industry’s intricate understanding, it is suggested that this leads to more practicable standards and to being more effectively policed.⁹⁵² On the other hand, a primary criticism of self-regulation is its frequent inability to fulfill its theoretical potential, frequently favoring industry interests over public welfare.⁹⁵³ In the words of the critics, “self-regulation is frequently an attempt to deceive the public into believing in the responsibility of an irresponsible industry. Sometimes it is a strategy to give the government an excuse for not doing its job”.⁹⁵⁴

In addition, government intervention is often viewed as a potential threat, prompting industries to resort to self-regulatory measures as a preemptive strategy to avert or delay external regulation.⁹⁵⁵ For instance, within the food industry, there is apprehension regarding the prospect of litigation and potential legislative or regulatory measures that may impact sales. In response, self-regulatory initiatives are implemented to mitigate the risk of adverse repercussions and to build trust.⁹⁵⁶

Industry self-regulation encompasses codes of conduct, product design, industry norms, collaborative agreements, self-accreditation, information disclosure, and self-ratings.⁹⁵⁷ Over

⁹⁴⁹ *ibid.*

⁹⁵⁰ Sammeck, *A New Institutional Economics Perspective on Industry Self-Regulation* (n 946).

⁹⁵¹ Lacy-Nichols and Williams, “Part of the Solution” (n 35) 845-856.

⁹⁵² Neil Gunningham and Joseph Rees, ‘Industry Self-Regulation: An Institutional Perspective’ (1997) 19 *Law & Policy* 363.

⁹⁵³ *ibid.*

⁹⁵⁴ *ibid.*; Peter N Grabosky and John Braithwaite, *Business Regulation and Australia’s Future* (Australian Studies in Law, Crime and Justice 1993).

⁹⁵⁵ Sharma, Teret and Brownell, ‘The Food Industry and Self-Regulation (n 945).

⁹⁵⁶ *ibid.*

⁹⁵⁷ Gostin and Wiley, *Public Health Law: Power, Duty, Restraint* (n 353) 215.

time, self-regulation has evolved from initially fragmented and comparatively weak corporate pledges/commitments to a cohesive and sector-wide framework of pledges/commitments tailored to address specific public health policy proposals.⁹⁵⁸

It has been underscored that rather than being static initiatives, self-regulatory efforts are increasingly recognized as “living documents” and adaptive programs that evolve in response to shifts in political and market contexts.⁹⁵⁹ To illustrate, an analysis of Kraft’s pledge in the US from 2003 shows that it referred to improving existing products and limiting the portion size of single-serve packages without offering concrete details or timelines.⁹⁶⁰ By contrast, the company’s 2021 commitments included clearly defined nutrient reduction targets and timeframes aligned with its Global Nutrition Guidelines.⁹⁶¹

In the context of unhealthy diets, companies like Kraft Foods and Coca-Cola have introduced self-regulatory measures on issues such as school food marketing, portion sizes, and product reformulation.⁹⁶² Industry self-regulation has been applied to mitigate the marketing of unhealthy food to children. In this scenario, self-regulatory systems include two fundamental components. First, a code of practice comprising ethically grounded guidelines governing the content of marketing campaigns. Secondly, a mechanism for the establishment, periodic review, and application of this code of practice (monitoring and enforcement).⁹⁶³

At a global level, the development of self-regulatory codes has been significantly shaped by the International Chamber of Commerce (ICC). The ICC has undertaken the development of a series of codes of practice delineating ethical standards for various marketing practices, each incorporating provisions addressing advertising to children. Many countries have adopted or modified the ICC codes to serve as the foundation for their national advertising self-regulatory frameworks.⁹⁶⁴

Analyses of self-regulation initiatives to reduce the marketing of unhealthy food to children have concluded that self-regulation is mostly ineffective, particularly because commitments in industry self-regulation schemes tend to be relatively vague and permissive.⁹⁶⁵ In conclusion,

⁹⁵⁸ Lacy-Nichols and Williams, “Part of the Solution” (n 35) 845-856.

⁹⁵⁹ *ibid.*

⁹⁶⁰ *ibid.*

⁹⁶¹ *ibid.*

⁹⁶² *ibid.*

⁹⁶³ Corinna Hawkes, ‘Self-Regulation of Food Advertising: What It Can, Could and Cannot Do to Discourage Unhealthy Eating Habits among Children’ (2005) 30 *Nutrition Bulletin* 374.

⁹⁶⁴ *ibid.*

⁹⁶⁵ K Ronit and JD Jensen, ‘Obesity and Industry Self-Regulation of Food and Beverage Marketing: A Literature Review’ (2014) 68 *European Journal of Clinical Nutrition* 753.

it has been described that the initiatives are not stringent enough to change the children's food and beverage marketing environment.⁹⁶⁶

2 Examples

2.1 EU Pledge

The EU Pledge is a voluntary initiative undertaken by predominantly large multinational food and beverage companies aimed at transforming advertising practices targeting children.⁹⁶⁷ The initiative revolves around three primary commitments: refraining from advertising food and beverage products to children under the age of thirteen across television, print, and internet platforms, except for products which fulfil common nutritional criteria, abstaining from promotional activities concerning products within primary school settings, unless expressly requested or approved by school authorities for educational purposes, and adhering to the International Chamber of Commerce Code of Advertising and Marketing Communication Practice as well as the ICC Framework for Responsible Food and Beverage Marketing Communications in all marketing communications.⁹⁶⁸

Established in 2007, the EU Pledge is part of the signatories' commitment to the European Union Platform for Action on Diet, Physical Activity and Health.⁹⁶⁹ In July 2021, the EU Pledge was formally submitted to the European Commission's Code of Conduct on Responsible Business and Marketing Practices, aligning with the Code's objectives and targets.⁹⁷⁰

One of the EU Pledge's main issues is the nutritional criteria in companies' commitments. It has been observed that there was a significant variation among companies regarding the specification of nutritional criteria, making their products eligible for marketing to children, resulting in less transparency and consistency.⁹⁷¹ Thus, in 2014, a common set of product-

⁹⁶⁶ Monique Potvin Kent, Lise Dubois and Alissa Wanless, 'Self-Regulation by Industry of Food Marketing Is Having Little Impact during Children's Preferred Television' (2011) 6 *International Journal of Pediatric Obesity* 401; Buse, Tanaka and Hawkes, 'Healthy People and Healthy Profits?' (n 35).

⁹⁶⁷ EU Pledge, 'About the EU Pledge' (*EU Pledge* 2014) <<https://eu-pledge.eu/about-the-eu-pledge/>> accessed 29 April 2024.

⁹⁶⁸ *ibid.*

⁹⁶⁹ *ibid.*

⁹⁷⁰ *ibid.*

⁹⁷¹ JD Jensen and K Ronit, 'The EU Pledge for Responsible Marketing of Food and Beverages to Children: Implementation in Food Companies' (2015) 69 *European Journal of Clinical Nutrition* 896.

specific nutritional criteria was established.⁹⁷² Nevertheless, the nutritional composition criteria for foods marketed to children under the EU Pledge is less stringent compared to the thresholds recommended by authoritative bodies such as the WHO.⁹⁷³ For instance, the EU Pledge permits the marketing of breakfast cereals with a maximum sugar content of 30 per cent.⁹⁷⁴ Moreover, even high-fat, high-salt crisps and snack foods are accommodated within the parameters of the nutritional criteria of the EU Pledge for healthy (non-HFSS) foods.⁹⁷⁵ This underlines the inherent issue of companies being entrusted with setting the criteria, resulting in standards that are perceived as inadequate and overly lenient to prevent obesity effectively.⁹⁷⁶

Two prominent concerns have been highlighted within the EU Pledge, both contributing to a lack of transparency. First, companies' interpretation of nutritional standards for advertised products is flexible. Second, a notable heterogeneity is observed in how companies communicate their respective commitments within the pledge. These issues collectively impede the transparency and clarity of the initiative's objectives and implementation.⁹⁷⁷

In addition, studies emphasized that the EU Pledge is ineffective in preventing the marketing of unhealthy foods to children, pointing out the issue of the nutrition criteria, the fact that these voluntary commitments do not apply to the entire food industry, and do not include marketing activities at the point of sale or sponsoring.⁹⁷⁸

Additional critical points have also been raised. The Pledge does not extend to all forms of media, and by limiting many of its provisions to marketing aimed solely at children under the age of 12, it allows participating companies to significantly restrict its scope, despite robust evidence that adolescents are similarly vulnerable to the marketing of unhealthy foods.⁹⁷⁹

Thus, persistent criticisms highlight that the EU Pledge remains insufficiently comprehensive in its coverage, whether in terms of products, companies, media platforms, or age groups, and

⁹⁷² *ibid.* In some cases the common criteria set the bar at a relatively low level.

⁹⁷³ Oliver Huizinga and Michaela Kruse, 'Food Industry Self-Regulation Scheme "EU Pledge" Cannot Prevent the Marketing of Unhealthy Foods to Children' (2016) 1 *Obesity Medicine* 24.

⁹⁷⁴ *ibid.*

⁹⁷⁵ *ibid.*

⁹⁷⁶ Stefanie C Landwehr and Monika Hartmann, 'Industry Self-Regulation of Food Advertisement to Children: Compliance versus Effectiveness of the EU Pledge' (2020) 91 *Food Policy* 101833.

⁹⁷⁷ Jensen and Ronit, 'The EU Pledge for Responsible Marketing of Food and Beverages to Children' (n 971).

⁹⁷⁸ Huizinga and Kruse, 'Food Industry Self-Regulation Scheme "EU Pledge"' (n 973).

⁹⁷⁹ Amandine Garde, Bill Jeffery and Neville Rign, 'Implementing the WHO Recommendations Whilst Avoiding Real, Perceived or Potential Conflicts of Interest' (2017) 8 *European Journal of Risk Regulation* 237.

that the food and beverage industry has yet to achieve full implementation of even these limited commitments.⁹⁸⁰

2.2 The International Food and Beverage Alliance

The International Food & Beverage Alliance (IFBA) is an international non-commercial, non-profit making association founded in 2008 by major food and non-alcoholic beverage companies “to empower consumers to eat balanced diets and live healthier lives, in support of the World Health Organization’s efforts to improve global public health”.⁹⁸¹ The IFBA includes ten global food and non-alcoholic beverage manufacturers (Coca-Cola Company, Ferrero, General Mills, Grupo Bimbo, Kellogg’s, Kraft Foods, Mars, Nestlé, PepsiCo, and Unilever) and is committed to improving the nutrition of their foods and beverages, empowering consumers to make informed choices through clear, nutritional information on product labels, online and at point-of-sale, restricting advertising to children and ensuring any child-directed marketing is compatible with healthy behaviors, and promoting healthy, sustainable living through a range of company initiatives through voluntary self-regulatory programs.⁹⁸²

Looking at the progress reports of IFBA and the commitments to public health, one can interpret that the companies have reduced the amount of sugar and sodium in their products and have responsible marketing practices for children.⁹⁸³ Nevertheless, obesity and NCD rates are still increasing worldwide.

In addition, under the Promotion of Healthy Lifestyles, the IFBA has launched several collaborations with civil society and governments. One example is the “Green Food Steps”, a partnership between Knorr and the government of Nigeria with the aim of combating anemia in the country through the use of Knorr’s iron-fortified stock cubes in popular dishes.⁹⁸⁴ It is scientifically proven that the Knorr bouillon cubes are full of sodium, which is also known as detrimental to people’s health and one of the biggest challenges regarding NCDs.⁹⁸⁵ Thus, this public-private partnership for food fortification in LMICs is problematic because it encourages

⁹⁸⁰ *ibid.*

⁹⁸¹ International Food & Beverage Alliance, ‘About Us’ (*IFBA*) <<https://ifballiance.org/about-us/>> accessed 30 April 2024.

⁹⁸² *ibid.*

⁹⁸³ International Food & Beverage Alliance, ‘IFBA Ten Year Progress Report 2008 – 2018’ (*IFBA* 2020) <<https://ifballiance.org/publications/ifba-ten-year-progress-report-2008-2018/>> accessed 31 August 2024.

⁹⁸⁴ Knorr, ‘About Us’ (*Knorr*) <<https://www.knorr.com/ng/about-us.html>> accessed 31 August 2023.

⁹⁸⁵ Nicholas S Archer and others, ‘Sodium Reduction in Bouillon: Targeting a Food Staple to Reduce Hypertension in Sub-Saharan Africa’ (2022) 9 *Frontiers in Nutrition*.

the consumption of an ultra-processed product that contains high levels of sodium and contributes to the high rates of hypertension and CVD in Sub-Saharan Africa.

Finally, a notable aspect of the IFBA's agenda is the promotion of "empowering consumers" which emphasizes the personal responsibility argument. This approach shifts the burden onto consumers rather than the companies themselves.

IV Corporate social responsibility

1 Definition

Corporate Social Responsibility was first introduced by BOWEN in 1953 as "the obligations of businessmen to pursue those policies, to make those decisions, or to follow those lines of action which are desirable in terms of the objectives and values of our society".⁹⁸⁶ In the early 1970s, DRUCKER described that there was a shift in the role of business in society, in which CSR "demands that business takes responsibility for social problems, social issues, social and political goals beyond their core business activities".⁹⁸⁷

There is a lot of debate around the definition of corporate social responsibility, which is not the focus of this research. Thus, as a matter of illustration, one of the primordial definitions of CSR is "corporate social responsibility represents a concern with the needs and goals of society which goes beyond the merely economic."⁹⁸⁸ It has also been described as "social responsibility of business that encompasses the economic, legal, ethical, and discretionary expectations that society has of organizations at a given point in time".⁹⁸⁹

Furthermore, the European Commission has defined Corporate Social Responsibility as "a concept whereby companies integrate social and environmental concerns in their business

⁹⁸⁶ Howard R Bowen, *Social Responsibilities of the Businessman* (University of Iowa Press 1953) 298.

⁹⁸⁷ Peter F Drucker, *Management: Tasks, Responsibilities, Practices* (Routledge 2011) 864 p 315.

⁹⁸⁸ Archie B Carroll, 'Corporate Social Responsibility: Evolution of a Definitional Construct' (1999) 38 *Business & Society* 268.

⁹⁸⁹ Archie B Carroll, 'A Three-Dimensional Conceptual Model of Corporate Performance' (1979) 4 *The Academy of Management Review* 497.

operations and their interaction with their stakeholders voluntarily”.⁹⁹⁰ These economic, social, and environmental concerns are frequently referred to as “the triple bottom line”.⁹⁹¹

One of the fundamental elements in a corporation’s social responsibilities is the degree of voluntarism, as opposed to coercion.⁹⁹² In addition, the idea is that CSR-related codes of conduct call for companies and industry groups to “voluntarily assume some of the costs associated with the industry’s negative externalities”.⁹⁹³

CSR has been widely adopted by various companies across different sectors and with distinct focus areas. For instance, through a sustainability lens focusing on environmental impacts or from a human rights approach emphasizing labor rights in the supply chain. In the case of the ultra-processed food and sugar-sweetened beverage industries, it also includes their “commitment to public health”. For instance, Nestlé’s CSR includes a pledge “supporting tasty and balanced diets” which states that “good nutrition is fundamental to everyone’s health and well-being”.⁹⁹⁴ Similarly, Coca-Cola’s health & wellness policy section asserts that the company “cares about the health of its consumers,” stating that their products “can be enjoyed as part of a healthy diet”.⁹⁹⁵

In the context of sugar-sweetened beverage companies’ use of corporate social responsibility, NESTLÉ defined CSR as “efforts to promote some social good – above and beyond legal requirements – aimed at benefiting employees, consumers, communities or the environment”.⁹⁹⁶ In her analysis, CSR can be perceived as a marketing strategy. This CSR strategy comprehends four socially responsible goals: firstly, promoting health initiatives to divert attention from the adverse health implications of sodas, thereby shifting responsibility to consumer physical inactivity and food poor choices; secondly, investing in sponsorships and community activities to cultivate brand loyalty and mitigate criticism; thirdly, supporting worthy causes such as sponsoring nutrition research and collaborating with health professionals, to boost credibility and influence policy-making; and finally, protecting the

⁹⁹⁰ Commission of the European Communities, *Green Paper: Promoting a European Framework for Corporate Social Responsibility* COM(2001) 366 final (Brussels, 18 July 2001).

⁹⁹¹ *ibid.*

⁹⁹² Carroll, ‘Corporate Social Responsibility: Evolution of a Definitional Construct’ (n 988).

⁹⁹³ S Prakash Sethi, ‘Self-Regulation through Voluntary Codes of Conduct’ in S Prakash Sethi (ed), *Globalization and Self-Regulation: the Crucial Role That Corporate Codes of Conduct Play in Global Business* (Palgrave Macmillan 2011).

⁹⁹⁴ Nestlé, ‘Supporting Balanced Diets’ (*Nestlé*) <<https://www.nestle.com/nutrition-health>> accessed 30 April 2024.

⁹⁹⁵ Coca-Cola, ‘Health & Wellness Policy’ (*Coca-Cola HBC* 2024) <<https://www.coca-colahellenic.com/en/about-us/corporate-governance/policies/health-wellness-policy>> accessed 30 April 2024.

⁹⁹⁶ Nestlé, *Soda Politics: Taking on Big Soda* (n 784) 231.

environment aimed at redirecting focus from the contribution of their products to issues such as water resource exploitation and climate change.⁹⁹⁷

2 Critiques

A primary critique of corporate social responsibility revolves around its portrayal as primarily a strategy aimed at achieving “innocence by association”. This suggests that corporations utilize CSR initiatives to align themselves with socially beneficial causes to enhance their public image and safeguard their core business interests.⁹⁹⁸ In this view, CSR would serve as a mechanism for improving corporate standing among various stakeholders such as consumers, the media, legislators, and regulators who play crucial roles in shaping policies related to the company and its offerings.⁹⁹⁹

Moreover, CSR initiatives would be introduced by corporations when they perceive threats to their profitability. For instance, CSR has been identified as a marketing strategy employed by Big Food and Big Soda to influence government policies while concurrently promoting their products, following the “playbook” of the tobacco industry on focusing on consumer empowerment.¹⁰⁰⁰

One of the strategies of major food and sugar-sweetened beverage industries is to promote physical activity through CSR, shifting the focus from the health implications of their unhealthy products and placing the responsibility on individuals for a lack of physical activity, thereby reinforcing the argument for personal responsibility.¹⁰⁰¹ For instance, Coca-Cola’s corporate Social Responsibility includes “the Company supports activities promoting fitness and physical exercise.”¹⁰⁰² Moreover, commercial slogans such as “Happiness is the movement” and the sponsorship of sporting events and other physical activity programs highlight the strategy of redirecting attention away from their products.¹⁰⁰³

⁹⁹⁷ *ibid*, 235-236.

⁹⁹⁸ Lori Dorfman and others, ‘Soda and Tobacco Industry Corporate Social Responsibility Campaigns: How Do They Compare?’ (2012) 9 PLoS Medicine.

⁹⁹⁹ *ibid*.

¹⁰⁰⁰ Nestle, *Soda Politics: Taking on Big Soda* (n 784) 233.

¹⁰⁰¹ Clare Herrick, ‘Shifting Blame/Selling Health: Corporate Social Responsibility in the Age of Obesity’ (2009) 31 *Sociology of Health & Illness* 51.

¹⁰⁰² Coca-Cola, ‘Health & Wellness Policy’ (*Coca-Cola HBC* 2024) <<https://www.coca-colahellenic.com/en/about-us/corporate-governance/policies/health-wellness-policy>> accessed 1 May 2024.

¹⁰⁰³ Nestle, *Soda Politics: Taking on Big Soda* (n 784).

In addition, one of the strategies to promote physical activity is sponsoring sporting activities and events. For instance, McDonald’s sponsors amateur hockey leagues for children aged 10 to 11 years in Canada.¹⁰⁰⁴ Similarly, Danone has held a branded international soccer tournament (Danone Nations Cup) for children between the ages of 10 and 12 years, which included a commitment to “healthier habits”.¹⁰⁰⁵

Furthermore, the company Nestlé claims to promote balanced diets and healthy lifestyle habits for children aged 3–12 years and supports parents and caregivers to raise healthier kids through its program Nestlé “for Healthier Kids”.¹⁰⁰⁶ Nevertheless, recently, it has been exposed that Nestlé adds high levels of sugar to two of its top-selling baby-food brands marketed in LMICs, namely Nido and Cerelac.¹⁰⁰⁷ This contradicts the WHO’s recommendations for sugar consumption among babies and children, as well as Nestlé’s public assertions to “avoid baby foods that contain added sugar” and contribute to childhood obesity.

It has been explored that CSR activities can create a phenomenon known as a “health halo”, which is a “general perception, driven by inference making, that a product is healthy across a range of attributes”.¹⁰⁰⁸ This perception of a health halo is shaped by the expectation that the firm is dedicated to the interests of stakeholders, promoting their well-being. Consequently, this perception can directly influence consumer behavior, leading to increased consumption levels of products marketed by such firms. In effect, this grants consumers a “license” to indulge in higher levels of consumption.¹⁰⁰⁹ As a result of the health halo effect, CSR initiatives can be economically beneficial for food and beverage companies, ultimately contributing to increased profits.¹⁰¹⁰

¹⁰⁰⁴ Monique Potvin Kent and others, ‘The Physical Activity and Nutrition-Related Corporate Social Responsibility Initiatives of Food and Beverage Companies in Canada and Implications for Public Health’ (2020) 20 *BMC Public Health*.

¹⁰⁰⁵ Danone, ‘Danone Nations Cup’ (*Danone Nations Cup* 2022) <<https://www.danonenationscup.com/en/change-the-game/>> accessed 1 May 2024.

¹⁰⁰⁶ Nestlé, ‘Nestlé for Healthier Kids’ (*Nestlé* 2024) <<https://www.nestle.com/nutrition-health/healthy-kids>> accessed 1 May 2024.

¹⁰⁰⁷ Laurent Gaberell, Manuel Abebe and Patti Rundall, ‘How Nestlé Gets Children Hooked on Sugar in Lower-Income Countries’ (*Public Eye* 2024) <<https://stories.publiceye.ch/nestle-babies/>> accessed 1 May 2024.

¹⁰⁰⁸ John Peloza, Christine Ye and William J Montford, ‘When Companies Do Good, Are Their Products Good for You? How Corporate Social Responsibility Creates a Health Halo’ (2015) 34 *Journal of Public Policy & Marketing* 19.

¹⁰⁰⁹ *ibid.*

¹⁰¹⁰ Kent and others, ‘The Physical Activity and Nutrition-Related Corporate Social Responsibility Initiatives of Food and Beverage’ (n 1004).

3 Healthwashing

Finally, CSR activities can be interpreted as a strategy for “healthwashing”, a practice in which companies create a misleading health-conscious image while continuing to sell unhealthy products.¹⁰¹¹ This occurs when businesses promote healthy lifestyles while simultaneously encouraging the consumption of harmful goods or when they use CSR to shift consumer focus away from their products’ negative impacts.¹⁰¹²

Healthwashing has been defined as “when health is used as a selling argument by implying benefits or unharmed effects of a product when the reality is different, when health is instrumentalized to a corporation’s advantage, or when consumers are influenced to adopt a lifestyle with unhealthy products”.¹⁰¹³ Healthwashing aims to preserve brand reputation, sustain sales, and divert public attention from questionable products or unethical practices.¹⁰¹⁴

It has been identified that this phenomenon can occur at the product level, corporate level, and frequent-habits level.¹⁰¹⁵ At the product level, companies exaggerate the health benefits of a product or downplay its harmful effects on consumers’ health. At the corporate level, firms engage in health washing through strategic messaging that frames their business as health-conscious or socially responsible, often to obscure the public health risks associated with their operations. Finally, at a frequent-habits-level, some companies attempt to integrate their products into consumers’ daily routines under the guise of promoting well-being. This form of healthwashing occurs when firms position their products as essential to a “healthy lifestyle” even when they contribute to poor health outcomes.¹⁰¹⁶

CONCLUDING REMARKS ON PART 2

This part analyzed the existing public health legal responses to tackling non-communicable diseases. It began by outlining the normative framework through a rights-based approach, emphasizing the right to health and the right to adequate food as fundamental justifications for

¹⁰¹¹ Felix Delerm, Anna Galmiche and Melanie Levy, ‘Healthwashing: Corporate Communication Strategies in a Legal Gray Zone’ (2024) 36 LAW eCommons.

¹⁰¹² *ibid.*

¹⁰¹³ *ibid.*

¹⁰¹⁴ *ibid.*

¹⁰¹⁵ *ibid.*

¹⁰¹⁶ *ibid.*

legislative action in the NCD prevention landscape. States must respect, protect, and fulfill the right to health.

The discussion then turned to the interplay between legal regimes, particularly international trade law, which can pose challenges to the adoption of public health measures. This was followed by a mapping of the international framework governing NCD prevention. Notably, most international instruments addressing NCDs are non-binding and primarily offer recommendations for states. The growing emphasis on multi-stakeholder engagement is a recurring theme across the Political Declaration of High-level Meetings of the UNGA, the SDGs, the WHO Global Strategy, and the Global Action Plan. For instance, the draft implementation roadmap (2023–2030) for the Global Action Plan for the Prevention and Control of NCDs explicitly calls for “strengthening partnerships and fostering multisectoral and multistakeholder collaborations”.¹⁰¹⁷ Member States are encouraged to enhance governance structures that facilitate such engagements.¹⁰¹⁸

The analysis then shifted to the European Union’s approach, which has largely prioritized voluntary measures, such as the Obesity Prevention White Paper, with a strong emphasis on individual behavior and responsibility. At the domestic level, legal tools for NCD prevention are continually evolving. Nowadays, some countries have implemented taxation policies, such as SSB taxes, and imposed restrictions on the marketing of unhealthy products to children. More recently, mandatory front-of-package labeling has been introduced in several countries, not only to inform consumer choices but also to incentivize product reformulation.

Switzerland served as a case study, exemplifying a preference for voluntary measures over regulatory interventions in addressing NCDs. This was followed by an exploration of the idea of “new governance” in regulatory approaches and the key critiques of public health regulations, including concerns about paternalism and the perceived encroachment of the “nanny state” on personal responsibility. These critiques have, in turn, contributed to the increasing involvement of private actors in public health through self-regulation and corporate social responsibility. However, such private-sector responses have raised concerns regarding “health washing”, a practice in which corporations present themselves as promoting public health while continuing to market unhealthy products.

¹⁰¹⁷ World Health Organization, *Political Declaration of the Third High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases: Draft Implementation Road Map 2023–2030 for the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2030, Annex 1*, EB150/7 (2021).

¹⁰¹⁸ *ibid.*, para 39(a).

In summary, the predominance of “soft” approaches, coupled with the emphasis on cross-sector collaboration at the international and regional levels, the “new governance” theory, neoliberalism beliefs and resistance to paternalistic interventions at the domestic level, the perceived difficulty of regulating food industries since its tied to life’s necessities (unlike tobacco), and the belief in the value of private sector expertise on their (unhealthy) products, has laid the groundwork for the rise of PPPs in public health promotion and NCD prevention.

PART 3

PUBLIC-PRIVATE PARTNERSHIPS AS AN INNOVATIVE TOOL?

CHAPTER 9: TAXONOMY OF PUBLIC-PRIVATE PARTNERSHIPS

I Preliminary Remarks

PPPs in general emerged as a form of public policy innovation within the neoliberal order, weakening the role of the public sector and favoring market-based solutions to public challenges.¹⁰¹⁹ PPPs are frequently promoted on the premise that private actors possess greater technical expertise, innovation capacity, and operational flexibility.¹⁰²⁰

There have been incentives for public-private partnerships at the international, regional, and domestic frameworks. For instance, SDG Goal 17 is “Partnerships for the Goals” and aims to revitalize the global partnership for sustainable development.

In the context of NCD prevention, the strategies adopted by WHO often encourage the participation of the private sector.¹⁰²¹ In addition, the Political Declaration of the Third High-Level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases affirms “Scale up efforts to use (...) innovative solutions, through, inter alia, the promotion of public-private partnership to accelerate ambitious action towards the prevention and control of non-communicable diseases”.¹⁰²²

Furthermore, in 2012, within the scope of the FAO, it took place the Second International Conference on Nutrition (ICN2), a high-level intergovernmental meeting that focused global attention on addressing malnutrition in all its forms (including overweight and obesity and the diet-related noncommunicable diseases). The meeting included the participation of governments, civil society, and the private sector.¹⁰²³ The two main outcome documents, the “Rome Declaration on Nutrition” and the “Framework for Action” call for “strengthen and establish, as appropriate... multi-stakeholder mechanisms for food security and nutrition to

¹⁰¹⁹ Michael A Stevenson, ‘The Relevance of the Public–Private Partnership Paradigm to the Prevention of Diet-Associated Non-Communicable Diseases in Wealthy Countries’ (2015) 10 *Global Public Health* 930.

¹⁰²⁰ *ibid.*

¹⁰²¹ See Part 2, Chapter 5.

¹⁰²² UNGA, ‘Political declaration of the 3rd High-Level Meeting’ (n 68) para 30.

¹⁰²³ World Health Organization, ‘FAO/WHO Second International Conference on Nutrition (ICN2)’ (*WHO* 2014) <[https://www.who.int/news-room/events/detail/2014/11/19/default-calendar/fao-who-second-international-conference-on-nutrition-\(icn2\)](https://www.who.int/news-room/events/detail/2014/11/19/default-calendar/fao-who-second-international-conference-on-nutrition-(icn2))> accessed 7 May 2024.

oversee implementation of policies, strategies, programmes and other investments in nutrition”.¹⁰²⁴

As a result of the incentives at the international framework, paternalism criticism of state intervention through NCD prevention legal measures, the “new governance” theory, and the belief that engaging the private sector is essential for tackling complex health challenges, public–private partnerships have emerged as an alternative innovative tool to traditional command-and-control regulations in the context of NCD prevention. To illustrate that, the UK health minister, in justifying the adoption of the Responsibility Deal, stated: “By working in partnership, public health, commercial and voluntary organizations can agree practical actions to secure more progress, more quickly, with less cost than legislation”.¹⁰²⁵

By now, several countries have engaged with the private sector, trying to promote better practices regarding unhealthy foods. For instance, in Europe, food reformulation has been done mainly through voluntary agreements.¹⁰²⁶ Nevertheless, there is no specific definition of what constitutes these public-private partnerships for the prevention and control of non-communicable diseases or how to establish these partnerships. Therefore, it is imperative to adopt a definition for the means of this research.

To establish a comprehensive definition of PPPs for NCD prevention, this chapter will explore the taxonomy of the term. It will begin by examining the generic version of public-private partnerships, outlining its historical development, defining its key characteristics, and analyzing the legal frameworks. The chapter will then transition to the global health public-private partnerships, similarly providing an overview of their historical context, defining features, legal foundations, and illustrative examples. This approach will lay the groundwork for understanding the PPPs for NCD prevention.

II Public-private partnerships in general

¹⁰²⁴ Food and Agriculture Organization and World Health Organization, *Second International Conference on Nutrition, Rome, 19–21 November 2014: Conference Outcome Document – Framework for Action ICN2 2014/3 Corr.1* (October 2014, Rome and Geneva).

¹⁰²⁵ Part 3, Chapter 10, II, 2 Public Health Responsibility Deal.

¹⁰²⁶ Linda Kleis, Eva A Schulte and Anette E Buyken, ‘Reformulation across Europe. An Overview on Planned and Implemented Strategies in European Countries Other than Germany – Part 1’ (2020) 67 *Ernährungs Umschau*.

1 Historical Framework

The rise of public-private partnerships in their generic version must be understood against the backdrop of the transformation of the welfare state, the rise of neoliberalism, and the emergence of new public management. Following World War II, the welfare state became the dominant governance model, marked by a significantly expanded role for the state in the direct provision of public goods and services that individuals could not obtain independently. Public bodies played a central role in promoting citizens' economic and social well-being.¹⁰²⁷

However, by the 1970s, this model came under strain due to economic crises and growing doubts about the efficiency of state intervention.¹⁰²⁸ Influenced by neoliberal thought, for instance, HAYEK's critique of "the danger of state intervention", political discourse began to favor a reduced role for the state and increased reliance on market mechanisms.¹⁰²⁹

Neoliberalism, as an ideological framework, is grounded in market-oriented principles that posit the inherent superiority of markets, competition, and private enterprise over state-led governance and public sector administration.¹⁰³⁰ At its core, neoliberalism advances that economic markets and private actors are generally more effective than states, legal institutions, or bureaucratic structures in delivering better outcomes.¹⁰³¹

This ideological shift laid the groundwork for the emergence of new public management (NPM), which sought to "reinvent" government by applying private-sector principles to public administration.¹⁰³² Public administration began to rely heavily on instruments such as external audits, value-for-money assessments, and cost-benefit analyses to justify outsourcing and private involvement.¹⁰³³

As HOOD described, new public management signifies a departure from traditional models of public administration towards practices inspired by the private sector.¹⁰³⁴ Central to NPM is the incorporation of market and private sector logics.¹⁰³⁵ It emphasizes the idea that private actors can deliver public services more cost-effectively than the state. This belief is grounded in the

¹⁰²⁷ Yselt Marique and Steven Van Garsse, 'Public-Private Cooperation and Judicial Review: A Case Study Drawn from European Infrastructure Projects' (2018) 24 *European Public Law*.

¹⁰²⁸ *ibid.*

¹⁰²⁹ *ibid.*

¹⁰³⁰ Lachlan McDonald-Kerr and Gordon Boyce, 'Neoliberalism and New Public Management: Decision-Making and Accountability in a Public-Private Partnership' (2023) 37 *Accounting, Auditing & Accountability Journal*.

¹⁰³¹ *ibid.*

¹⁰³² Marique and Van Garsse, 'Public-Private Cooperation and Judicial Review' (n 1027).

¹⁰³³ *ibid.*

¹⁰³⁴ Christopher Hood, 'A Public Management for All Seasons?' (1991) 69 *Public Administration* 3.

¹⁰³⁵ McDonald-Kerr and Boyce, 'Neoliberalism and New Public Management' (n 1030).

assumption that the private sector would be more innovative and efficient, leading to improved outcomes at a lower cost.¹⁰³⁶

Within this context, PPPs emerged as an alternative form of public contracts for delivering public infrastructure and services. Their expansion was driven not only by ideological commitment to the efficiency of private actors but also by practical fiscal constraints, as governments increasingly lacked the financial capacity to invest in large-scale infrastructure on their own.¹⁰³⁷ PPPs thus reflect the budgetary limitations of the state and are promoted by NPM, particularly the belief that private actors can deliver public services more cost-effectively, innovatively, and efficiently than the state.

In this generic version, PPPs were initially developed for the construction of infrastructure projects such as roads, toll roads, hospitals, water systems, and power.¹⁰³⁸ In the mid-1990s, their scope expanded to include prisons, sea ports, and sports stadiums, and in the late 1990s, also on airports.¹⁰³⁹

In 2015, the Addis Ababa Action Agenda was adopted, and it is a crucial document to the PPP framework since it recognizes the key role played by the private sector and encourages the use of PPPs for sustainable development.¹⁰⁴⁰ Currently, PPPs are primarily linked to private contracts to run public services, for instance, railways, water services, and hospitals. Here, a public-private partnership is understood as “a contractual agreement between the public and the private sectors, whereby the private operator commits to provide public services that have traditionally been supplied or financed by public institutions.”¹⁰⁴¹

¹⁰³⁶ Johanna Hoekstra and Luis Felipe Yanes, ‘Chapter 7: The Mismatch of Public-Private Partnerships and the Right to Health’ in Olga Martin-Ortega and Laura Treviño-Lozano (eds), *Sustainable Public Procurement of Infrastructure and Human Rights* (Edward Elgar Publishing 2023).

¹⁰³⁷ Geert Dewulf, Anneloes Blanken and Mirjam Bult-Spiering, *Strategic Issues in Public-Private Partnerships* (John Wiley & Sons 2006).

¹⁰³⁸ Jane Broadbent and Richard Laughlin, ‘PPPs: Nature, Development and Unanswered Questions’ (2004) 14 *Australian Accounting Review* 4.

¹⁰³⁹ Dewulf, Blanken and Bult-Spiering, *Strategic Issues in Public-Private Partnerships* (n 1037).

¹⁰⁴⁰ Addis Ababa Action Agenda of the Third International Conference on Financing for Development UN Doc A/RES/69/313 (2015) para 48, endorsed by UNGA Res 69/313 (27 July 2015).

¹⁰⁴¹ European Parliament, DG Internal Policies of the Union – Directorate A – Economic and Scientific Policy, *Public-Private Partnerships: Models and Trends in the European Union* IP/A/IMCO/SC/2005-16 (February 2006).

2 Key characteristics

First, it is central to distinguish PPPs from full privatization and from conventional public procurement. In traditional procurement, the private contractor typically bears little risk, most of which remains with the contracting authority. PPPs, by contrast, allocate a material share of construction, financing, and operational risk to the private partner, and in full privatization transfers virtually the entire risk and ownership into private hands.¹⁰⁴²

PPPs have been categorized as a “lower-intensity privatization method”.¹⁰⁴³ However, there are important legal and functional distinctions between the two. Privatization refers to an arrangement in which private entities manage public assets or services on a permanent and independent basis, often within a competitive market framework that includes other private or, in certain cases, public providers.¹⁰⁴⁴ In cases of full privatization, the public sector relinquishes ownership and control of the asset or service in question. PPPs, by contrast, are typically structured through long-term (not permanent), contractual arrangements, wherein the public sector retains ultimate ownership and oversight authority.¹⁰⁴⁵

The functions of the private party can change depending on the type of asset and service involved. The World Bank has identified the following typical functions of the private party: design (when the private party is responsible for the development of the project from initial concept); build or rehabilitate (when the private party is responsible for building a new or rehabilitating an existing asset); finance (when the private party is responsible for financing which can be integrally or in part) maintain (when the private party is responsible for maintaining the asset to a specified standard over the life of the contract); and operate (when the private party is responsible for operating the asset).¹⁰⁴⁶

Furthermore, PPPs also have different types of remuneration mechanisms. It varies from “user-pays” PPPs in which the private party will provide a service to users and generate revenues by charging fees from the users, and “government-pays” PPPs in which the government is the only

¹⁰⁴² Laura Treviño-Lozano and Olga Martin-Ortega, ‘Chapter 1: Sustainable Public Procurement of Infrastructure and Human Rights: Linkages and Gaps’ in Olga Martin-Ortega and Laura Treviño-Lozano (eds), *Sustainable Public Procurement of Infrastructure and Human Rights* (Edward Elgar Publishing 2023) 6.

¹⁰⁴³ John Kitsos, ‘Privatisation and Public Private Partnerships: Defining the Legal Boundaries from an International Perspective’ (2015) 10 *European Procurement & Public Private Partnership Law Review* 17.

¹⁰⁴⁴ Martin-Ortega and Treviño-Lozano, ‘Chapter 1: Sustainable Public Procurement of Infrastructure and Human Rights: Linkages and Gaps’ (n 1042) 6.

¹⁰⁴⁵ *ibid.*

¹⁰⁴⁶ World Bank Group, ‘PPP Reference Guide - PPP Basics’ (World Bank Group 2017) <<https://ppp.worldbank.org/public-private-partnership/library/ppp-reference-guide-ppp-basics>> 6, accessed 7 July 2025.

source of revenue for the private party to recuperate the investment.¹⁰⁴⁷ A crucial term in PPPs is concession, which in some jurisdictions means a specific type of contract, whereas in others, it is used more broadly. In the PPP context, a concession is mainly used to describe a user-pays PPP.¹⁰⁴⁸

PPPs have primarily been used as financing tools. However, this is not absolute and can change depending on the country. For instance, in Germany and France, PPPs are not seen as just a tool to finance projects or to create off-balance investments. In this case, PPPs would only be feasible if they represent the most efficient choice compared to other solutions.¹⁰⁴⁹

Here is important to make a brief remark on a new approach adopted by the United Nations Economic Commission for Europe (UNECE).¹⁰⁵⁰ With the need to expand PPPs to support and benefit the people, the UNECE recently developed the PPPs for the SDGs. These Public-Private Partnerships are designed to implement Sustainable Development Goals with the aim of not only bringing “value for money but also value for people and value for the planet.”¹⁰⁵¹ As previously mentioned, SDG 3.4 aims to reduce by one-third premature mortality from non-communicable diseases through prevention and treatment. Although it can be interpreted that PPPs for NCD prevention are also focused on achieving the SDGs, they are still excluded from the discussion of UNECE concerning PPPs for the SDGs.¹⁰⁵²

The COVID-19 pandemic highlighted the use of PPPs for health. For instance, Operation Warp Speed was a public-private partnership in the US that mobilized government agencies, the military, and private pharmaceutical companies to accelerate vaccine development. Operation Warp Speed merged the resources of the Departments of Health and Human Services and Defense and reduced logistical and regulatory barriers to facilitate the collaboration between government and private entities. The project’s clear goal, producing and delivering 300 million safe vaccines, created alignment across organizations toward the shared objective.¹⁰⁵³

¹⁰⁴⁷ *ibid.*, 8.

¹⁰⁴⁸ *ibid.*, 9.

¹⁰⁴⁹ UN Economic Commission for Europe, *Introduction to Public-Private Partnerships in support of the United Nations Sustainable Development Goals: Revised note by the secretariat* (6 September 2022) UN Doc ECE/CECI/WP/PPP/2022/6.

¹⁰⁵⁰ The UNECE aims to promote pan-European economic integration and has special focus in Public-Private Partnerships.

¹⁰⁵¹ UNECE, *Introduction to Public-Private Partnerships in support of the UN SDGs* UN Doc ECE/CECI/WP/PPP/2022/6 (n 1049).

¹⁰⁵² In the provisions dedicated to health (para 35-37) only healthcare services and infrastructure is mentioned.

¹⁰⁵³ U.S. Government Accountability Office, ‘Operation Warp Speed: Accelerated COVID-19 Vaccine Development Status and Efforts to Address Manufacturing Challenges’ (GAO 2021) <<https://www.gao.gov/products/gao-21-319>>.

PPPs have been introduced as an alternative innovative management or governance tool to achieve more efficiency and effectiveness in the public sector. The main key elements of PPPs in its original format are voluntary, contractual agreements, long-term duration, involving the private and public sectors (government) that come together to provide public assets or services, with a certain degree of shared risks and responsibilities. Furthermore, it is crucial to keep in mind that original PPPs have a structured format, mostly characterized by a contract that has a defined term duration to deliver infrastructure projects.

Finally, the principal benefits recognized of these PPPs are the enhancement of government capacity to develop integrated solutions, being a creative and innovative solution, the cost and time reduction for the implementation of projects, the transfer of certain risks to the private partner, and the access to skills, experience, and technology.¹⁰⁵⁴ The aim of this thesis is not to explore in further detail public-private partnerships models, contract types, laws, and characteristics, but mostly to give an overview of this “original” format of PPPs to better understand the PPPs focus of this research: PPPs for non-communicable diseases prevention.

3 Definition

The original format of PPP is already considered a blurred term with different interpretations. It has been defined as “a cooperation of some sort of durability between public and private actors in which they jointly develop products and services, even according to co-production modes, and share risks, costs, and resources that are connected with these products”.¹⁰⁵⁵ Or also “a contractual arrangement to deliver public services, as an intermediate solution between traditional public driven and privatized solutions.”¹⁰⁵⁶

The UN Global Compact defines PPP as “voluntary and collaborative relationships between various parties, both State and non-state, in which all participants agree to work together to

¹⁰⁵⁴ Bing Li and Akintola Akintoye, ‘Chapter 1: an Overview of Public-Private Partnership’ in Akintola Akintoye, Matthias Beck and Cliff Hardcastle (eds), *Public-Private Partnerships: Managing Risks and Opportunities* (Wiley-Blackwell 2003) 7-9.

¹⁰⁵⁵ Veronica Vecchi, Stefano Caselli and Guido Corbetta, ‘Chapter 1: the Public-Private Partnerships’ Framework’ in Stefano Caselli, Veronica Vecchi and Guido Corbetta (eds), *Public Private Partnerships for Infrastructure and Business Development* (Palgrave Macmillan 2015) 1.

¹⁰⁵⁶ *ibid.*

achieve a common purpose or undertake a specific task and to share risks and responsibilities, resources and benefits.”¹⁰⁵⁷

Moreover, the UN General Assembly in 2003 defined PPPs as “voluntary and collaborative relationships between various parties, both State and non-State, in which all participants agree to work together to achieve a common purpose or undertake a specific task and to share risks, responsibilities, resources, competencies and benefits.”¹⁰⁵⁸

The UNCITRAL Legislative Guide on Public-Private Partnerships, from 2019 defines the term as “used in practice to refer to a wide variety of contractual arrangements or joint ventures through which the public and private sector cooperate towards a common purpose, and there is no internationally acknowledged legal definition covering all possible variants”.¹⁰⁵⁹ It goes further and specifies that “refer to long-term arrangements between public authorities and private entities contributing to the private financing of public infrastructure in the broad sense.”¹⁰⁶⁰

In 2017, the World Bank described it as “a long-term contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility and remuneration is linked to performance”.¹⁰⁶¹

Moreover, the United Nations Economic Commission for Europe Committee on Innovation, Competitiveness, and Public-Private Partnerships published in 2022 a Standard on Private-Public Partnerships/Concession Model law in which the definition of PPP is a “long-term agreement between a contracting authority and a private entity for the implementation of a project, against payments by the contracting authority or the users of the [facility], including both those projects that entail a transfer of the demand risk to the private partner (“concession PPPs”) and those other types of PPPs that do not entail such risk transfer (“government-pay PPPs”) meeting the criteria and requirements set out in Art. 4.3.”¹⁰⁶²

¹⁰⁵⁷ United Nations Global Compact, *Guidelines on a Principle-based Approach to the Cooperation between the United Nations and the Business Sector* (2015) para 8(a).

¹⁰⁵⁸ UN General Assembly, ‘Enhanced cooperation between the United Nations and all relevant partners, in particular the private sector : report of the Secretary-General’ (8 August 2003) UN Doc A/58/227 para 9.

¹⁰⁵⁹ United Nations Commission on International Trade Law, *Legislative Guide on Public-Private Partnerships* (2019) para 14.

¹⁰⁶⁰ *ibid.*

¹⁰⁶¹ WBG, ‘PPP Reference Guide - PPP Basics’ (n 1046).

¹⁰⁶² United Nations Economic Commission for Europe, *Document ECE/CECI/WP/PPP/2022/5* (18 October 2022).

4 Legal framework

Preliminary remarks

Although one of the main characteristics of PPP is the voluntary nature, it is widely recognized that regulatory measures are imperative to ensure the balance of public and private interests within these collaborative arrangements.¹⁰⁶³ Regulation should be designed to safeguard the collective welfare. A clear legislative framework delimiting the roles of the public and the private sector, their relationships demarcating the spheres of cooperation, is pivotal for the establishment of enduring and viable partnerships.¹⁰⁶⁴

According to the World Bank Guidance on PPP Legal Frameworks, a PPP legal framework includes laws, regulations, and non-legally binding instruments that govern the full lifecycle of PPP projects and grant legal authority to the entities responsible for their implementation.¹⁰⁶⁵ In detail, this framework may include PPP-specific legislation and regulations (either as primary or secondary legislation), official government-issued guidelines, manuals, or other documents tailored to PPPs, as well as broader legal instruments that, while not PPP-specific, can influence these projects. Examples of such broader legislation include sector-specific regulations and laws governing procurement, contracts, companies, arbitration, or environmental matters.¹⁰⁶⁶

The Guidance emphasizes that PPPs must align with the country's existing legal and regulatory frameworks. Specifically, in relation to procurement, the implementation of PPPs may rely on various legal instruments, which can vary depending on the jurisdiction's legal system.¹⁰⁶⁷

The World Bank highlights the importance of a well-defined legal framework as a cornerstone for successful PPPs.¹⁰⁶⁸ It acknowledges potential tensions between the objectives of government entities and private partners, as each party may have distinct motivations. To address this, a carefully designed PPP legal framework can preemptively balance these

¹⁰⁶³ Nutavoot Pongsiri, 'Regulation and Public-Private Partnerships' (2002) 15 *International Journal of Public Sector Management* 487.

¹⁰⁶⁴ *ibid.*

¹⁰⁶⁵ World Bank Group, 'World Bank Guidance on PPP Legal Frameworks' (2022) <<https://ppp.worldbank.org/public-private-partnership/library/world-bank-guidance-ppp-legal-frameworks>> accessed 7 July 2025.

¹⁰⁶⁶ *ibid.*

¹⁰⁶⁷ *ibid.*

¹⁰⁶⁸ *ibid.*

competing interests on an ex-ante basis, enabling governments to adopt a proactive rather than reactive approach to managing such dynamics.¹⁰⁶⁹

Hence, the PPP in its original format can be considered a topic of public law, particularly admirative law, which is mostly based on domestic legislation, which varies from country to country. Nevertheless, it also involves other areas of law, such as intellectual property, company law, tax law, consumer protection laws, etc.¹⁰⁷⁰

*Contractual Framework*¹⁰⁷¹

It is essential to highlight that the PPP format under consideration is grounded in a contractual arrangement. PPPs have been described as “complex contracts” that assume diverse forms and differ in their regulation by domestic law.¹⁰⁷²

The UNCITRAL Legislative Guide on Public-Private Partnerships established a general legal institutional framework for the establishment of PPPs. It presents guiding principles that comprehend public interest, transparency, fairness, stability and predictability, proper management, integrity and accountability, economy and efficiency, and long-term sustainability.¹⁰⁷³ In addition, it affirms that commonly, the legal framework for PPPs will comprehend a primary law or set of laws, secondary regulations or decrees, internal rules and guidance, drawing on the policy choices made by the legislator and the Government.¹⁰⁷⁴

In relation to the decision-making process, the UNCITRAL Legislative Guide affirms that the existing domestic law must effectively regulate the meetings of the shareholders and meetings of management organs of the company (the board of directors or supervisory). Furthermore, it should also incorporate mechanisms for the resolution of conflicts among shareholders.¹⁰⁷⁵

Concerning the implementation of the PPP contract, the legislative guide elucidates that this process is undertaken through domestic legal frameworks.¹⁰⁷⁶ Most countries consider these

¹⁰⁶⁹ *ibid.*

¹⁰⁷⁰ *ibid.*

¹⁰⁷¹ As contractual frameworks for PPPs vary across jurisdictions, and given that this thesis does not focus on these specific PPP models, the analysis here remains general, drawing primarily on international instruments rather than detailed domestic legal provisions.

¹⁰⁷² Martín-Ortega and Treviño-Lozano, ‘Chapter 1: Sustainable Public Procurement of Infrastructure and Human Rights: Linkages and Gaps’ (n 1042) 5.

¹⁰⁷³ UNCITRAL, *Legislative Guide on Public-Private Partnerships* (n 1059) 26-32.

¹⁰⁷⁴ *ibid.*, 34 para 24.

¹⁰⁷⁵ *ibid.*, 136 para 6; 256 para 34.

¹⁰⁷⁶ *ibid.*, 135 para 2.

PPPs as a category of public contract and thus are governed by the national law of the contracting authority.¹⁰⁷⁷ In some cases, the law establishes the demand for an agreement between the private partner and the contracting authority, and, in other countries, stipulates extensive mandatory provisions concerning the content of the clause.¹⁰⁷⁸ Moreover, it highlights that the applicable law to a PPP contract might contain rules of administrative law or other public law nature of the host country.¹⁰⁷⁹ However, some countries govern PPPs through private law contractual frameworks.¹⁰⁸⁰

The PPP contract generally specifies the duration of the agreement and the protocols for transferring project assets back to the government. It outlines the circumstances under which the contract may be terminated prematurely, typically resulting in the reversion of project assets to the public sector. In essence, there are three primary reasons for early termination: default by the private party, termination by the public party, whether due to default or for reasons of public interest, and early termination due to an external reason (force majeure).¹⁰⁸¹

Concerning judicial review, the enforcement and adjudication of disputes arising from PPPs depend significantly on the legal characterization of the underlying contract and the jurisdiction in which it is executed. In many legal systems, PPP contracts are considered public contracts and therefore fall under the domain of public law, with disputes typically resolved before administrative courts. In other jurisdictions, however, civil law may apply, particularly in the context of public procurement litigation or arbitration. The choice of forum, whether an administrative court, civil court, or arbitral tribunal, has direct implications for enforcement.¹⁰⁸²

Human rights

PPPs in general raise a distinctive set of human-rights questions. States remain bound by the tripartite levels of obligations to respect, protect, and fulfil human rights.¹⁰⁸³ Parallel to these duties, the United Nations Guiding Principles on Business and Human Rights (UNGPs) require

¹⁰⁷⁷ *ibid*, 136 para 5.

¹⁰⁷⁸ *ibid*, 135 para 2.

¹⁰⁷⁹ *ibid*, 136 para 6.

¹⁰⁸⁰ Marique and Van Garsse, 'Public-Private Cooperation and Judicial Review' (n 1027).

¹⁰⁸¹ World Bank Group, 'Termination Provisions' (*Public-Private Partnership Resource Center*) <<https://ppp.worldbank.org/public-private-partnership/termination-provisions>> accessed 8 July 2025.

¹⁰⁸² Christopher Bovis, 'Judicial Review of Public Private Partnerships' (2007) 2 *European Procurement & Public Private Partnership Law Review* 8.

¹⁰⁸³ Part 2, Chapter 4, III, 1.3 Tripartite typology of obligations.

business enterprises to “respect” human rights.¹⁰⁸⁴ The involvement of private actors in the provision of public services through PPPs does not absolve the state of its primary obligations. Consequently, the delegation of public functions to a private partner in a PPP does not dilute these normative responsibilities.

In this regard, it is important to highlight Guiding Principle 5 of UNGPs, which affirms that when States contract with or legislate for business enterprises to provide services with potential human rights implications, they must exercise adequate oversight to ensure compliance with their human rights obligations.¹⁰⁸⁵ The Commentary to Principle 5 further stresses that such contracts should explicitly articulate the expectation that business partners will respect human rights throughout their operations.¹⁰⁸⁶

It has been observed that PPPs exemplify precisely this type of relationship, in which states contract with private entities to design, build, or operate infrastructure and deliver essential public services, including health, education, and transportation.¹⁰⁸⁷ Thus, the legal instruments governing these partnerships must include specific provisions that clarify the State’s expectations that these enterprises respect human rights. States should ensure that they can effectively oversee the enterprises’ activities, including through the provision of adequate independent monitoring and accountability mechanisms.¹⁰⁸⁸

The CESCR, in General Comment No. 24 on State obligations under the ICESCR in the context of business activities, expressly recognizes that the growing involvement of private actors in sectors such as health and education “poses new challenges” for States parties in complying with their obligations under the Covenant under the context of privatization.¹⁰⁸⁹ While the provisions discussed in the General Comment are situated in the context of privatization, the reasoning can be extended to PPPs, given the similar dynamics of private involvement in public service delivery.

The Committee stresses that, even where services are provided by non-State actors, the State must ensure availability, accessibility, acceptability, and quality on a continuing basis. To that

¹⁰⁸⁴ See Part 4, Chapter 12, I, 4.

¹⁰⁸⁵ UN Office of the High Commissioner for Human Rights, *Guiding Principles on Business and Human Rights: Implementing the United Nations “Protect, Respect and Remedy” Framework* (2011) principle 5.

¹⁰⁸⁶ *ibid.*

¹⁰⁸⁷ Martin-Ortega and Treviño-Lozano, ‘Chapter 1: Sustainable Public Procurement of Infrastructure and Human Rights: Linkages and Gaps’ (n 1042).

¹⁰⁸⁸ *ibid.*

¹⁰⁸⁹ CESCR, ‘*General Comment No. 14*’ UN Doc E/C.12/2000/4 (n 406) para 22.

end, private providers ought to be subject to robust “public-service obligations” and to regular, transparent oversight.¹⁰⁹⁰

In relation to remedies, General Comment No. 24 identifies two key avenues of redress in the context of business-related human rights violations. First, that States should consider using administrative sanctions to discourage conduct by business entities that leads, or may lead, to violations of the rights under the ICESCR. A practical example given is in the case of public procurement regimes where States could deny the awarding of public contracts to companies that have not provided information on the social or environmental impacts of their activities or that have not put in place measures to ensure that they act with due diligence to avoid or mitigate any negative impacts on the rights under the ICESCR.¹⁰⁹¹

A second avenue arises when a violation is directly attributable to a business entity. In such cases, victims should have the ability to bring legal action against the entity, either directly under the ICESCR in jurisdictions that recognize the ICESCR as creating self-executing obligations for private actors, or through domestic legislation that incorporates the ICESCR into national law. In this context, access to civil remedies is essential to ensure that victims of rights violations can seek and obtain justice.¹⁰⁹²

In an analysis of PPPs in the generic version and the right to health, it has been pointed out a persistent gap: most PPP contracts and enabling statutes do not expressly articulate the human-rights obligations of either the State or the private party.¹⁰⁹³ Furthermore, practical examples of PPPs in infrastructure projects highlight that ensuring access to grievance mechanisms for victims whose human rights are violated during the execution of a PPP contract remains an ongoing challenge.¹⁰⁹⁴

¹⁰⁹⁰ *ibid*, para 21.

¹⁰⁹¹ *ibid*, para 50.

¹⁰⁹² *ibid*.

¹⁰⁹³ Johanna Hoekstra and Luis Felipe Yanes, ‘Chapter 7’ (n 1036).

¹⁰⁹⁴ Martin-Ortega and Treviño-Lozano, ‘Chapter 1: Sustainable Public Procurement of Infrastructure and Human Rights: Linkages and Gaps’ (n 1042).

III Global health public-private partnerships

PPPs have been implemented at the national level in the health sector.¹⁰⁹⁵ Additionally, PPPs, termed global health public-private partnerships, are a common public health tool at the international level, which introduces unique legal and governance challenges.¹⁰⁹⁶

1 Historical framework

The growing role of the private sector in health began to appear in the latter 1990s and the beginning of the 2000s with the global health public-private partnerships.¹⁰⁹⁷ This shift has been a result of neoliberal theories and the idea about the efficiency of the private sector and the supposed superiority of market mechanisms in delivering goods and services.¹⁰⁹⁸ This new model of PPPs focused on health development. In particular, to develop drugs and vaccines and to increase access to medicines in low-income countries.¹⁰⁹⁹

The globalization scenario, the failure of the market to deal with mortality and morbidity trends in developing countries, access to resources (financial, technical, scientific), the rising doubts regarding the effectiveness of the UN and its agencies, and the acknowledgment of the complexity of health problems, meaning no single sector would be able to tackle them alone are the main reasons that created a fertile ground for the origin of global health public-private partnerships.¹¹⁰⁰

For instance, in 1990, Gro Harlem Brundtland (the World Health Organization's Director-General from 1998 to 2003) declared, "Partnership is what is needed in today's world, partnership between government and industry, between producers and consumers, between the present and the future. We need to build new coalitions. We must agree on a global agenda for the management of change... We must continue to move from confrontation, through dialogue to cooperation. Collective management of the global interdependence is the only acceptable

¹⁰⁹⁵ See example of Operation Warp Speed Part 3, Chapter 9, II, 2 Key characteristics.

¹⁰⁹⁶ The emphasis of this research is not the global health public-private partnerships. Nevertheless, it is imperative to introduce this concept to subsequently establish the similarities and differences between the public-private partnerships for non-communicable disease prevention.

¹⁰⁹⁷ Kent Buse and Gavin Walt, 'Global Public-Private Partnerships: Part I – A New Development in Health?' (2000) 78 *Bulletin of the World Health Organization* 549–559 (ODI Document for WHO).

¹⁰⁹⁸ Arne Ruckert and Ronald Labonté, 'Public-Private Partnerships (PPPs) in Global Health: The Good, the Bad and the Ugly' (2014) 35 *Third World Quarterly* 1598.

¹⁰⁹⁹ Corinna Hawkes, *High-Level Group Working Paper on Public-Private Partnerships for Health*, Working Paper on Public-Private Partnerships for Health (November 2008).

¹¹⁰⁰ Buse and Walt, 'Global Public-Private Partnerships: Part I' (n 1097).

formula in the world of the 1990s”.¹¹⁰¹ Moreover, he stated that “in a world filled with complex health problems, WHO cannot solve them alone. Governments cannot solve them alone. Nongovernmental organizations, the private sector, and foundations cannot solve them alone. Only through new and innovative partnerships can we make a difference. Whether we like it or not, we are dependent on the partners to bridge the gap and achieve health for all”.¹¹⁰²

2 Key characteristics

The three main elements identified in global health PPPs are that these partnership tackles a specific health issue as its central concern, they are institutionalized to share resources and manage risks and finally they involve a different range of public and private actors such as government, nongovernment organization, philanthropic and private sector agencies.¹¹⁰³

In the literature, there are many different attempts to categorize these GPPPs. For instance, public-private partnerships for health have been divided into categories according to their purpose: partnerships for disease control which can be focused on product development or product distribution; partnerships for strengthening health services; partnerships to commercialize traditional medicines; partnerships for health program coordination; partnerships for product donations; partnerships for health service delivery other international health partnerships.¹¹⁰⁴

In addition, BURCI has identified three major functions: financing developing countries’ health programs through interventions, such as immunization, sanitation or availability of medical products; raising awareness about health issues by coordinating actions of diverse partners around specific diseases or health conditions and promote research therefore being an incentive for the development of new medicines, vaccines and diagnostics.¹¹⁰⁵ GOSTIN has described that GPPPs operate with different areas of focus and functions: research and development, technical assistance, health service/system support, advocacy, coordination, and finance.¹¹⁰⁶

¹¹⁰¹ Judith Richter, ‘Public–Private Partnerships for Health: A Trend with No Alternatives?’ (2004) 47 *Development* 43.

¹¹⁰² *ibid.*

¹¹⁰³ Hurriyet Babacan, ‘Public–Private Partnerships for Global Health’ in Robin Haring and others (eds), *Handbook of Global Health* (Springer 2021).

¹¹⁰⁴ Michael Reich, *Public-Private Partnerships for Public Health* (Harvard Center for Population and Development Studies 2002) 5.

¹¹⁰⁵ Burci, ‘Public/Private Partnerships in the Public Health Sector’ (n 26).

¹¹⁰⁶ Gostin, *Global Health Law* (n 3).

PPPs have also been categorized based on their governance models. For instance, BURCI presents four governance models of GPPPs: networks, programs with external participation, formal partnerships or alliances, and separate organizations.¹¹⁰⁷ Networks are characterized as loosely structured groups in which participants meet periodically to exchange information and views, coordinate strategies, facilitate advocacy, or provide advice to participating organizations. In addition, networks are supported by an existing institution, nevertheless, the activities are mostly carried out by individual partners.¹¹⁰⁸

Programs with external participation are long-term, structured programs developed by an existing international agency and managed by it. They also involve public and private stakeholders who provide, inter alia, financial support. They are based on instruments such as terms of reference, strategic frameworks, or guiding principles.¹¹⁰⁹

Formal partnerships or alliances are highly structured initiatives recognized as entities. They are hosted by an existing organization and have an executive body with the authority to make decisions on behalf of its members. However, they are not separate legal entities.¹¹¹⁰ The two main examples would be the Roll Back Malaria partnerships and the Stop TB Partnerships.¹¹¹¹

Finally, separate organizations such as the GAVI Alliance and the Global Fund to Fight AIDS. These PPPs are constituted as separate legal entities, with the administrative and legal structure of a non-profit corporation or trust under national law. In addition, they have a highly developed governance structure and a governing body with members from the private and public sectors. The legal status depends on the applicable national law or arrangements with the host country.¹¹¹²

Looking at the definitions and categories presented above, it is crucial to point out that global health public-private partnerships often involve UN agencies and tend to be institutionalized initiatives.¹¹¹³ In addition, global public-private partnerships do not always include for-profit representation and, in some cases, when including corporate representatives, can lack voting rights on the governing boards.¹¹¹⁴

¹¹⁰⁷ Burci, 'Public/Private Partnerships in the Public Health Sector' (n 26).

¹¹⁰⁸ *ibid.*

¹¹⁰⁹ *ibid.*

¹¹¹⁰ *ibid.*

¹¹¹¹ Lisa Clarke, *Public-Private Partnerships and Responsibility under International Law* (Routledge 2014) 7.

¹¹¹² Burci, 'Public/Private Partnerships in the Public Health Sector' (n 26).

¹¹¹³ Hawkes, *High-Level Group Working Paper on Public-Private Partnerships for Health* (n 1099).

¹¹¹⁴ Gostin, *Global Health Law* (n 3).

ANDONOVA defines these PPPs as “voluntary agreements between public actors (IOs, states, or substate public authorities) and nonstate actors (nongovernmental organizations [NGOs], companies, foundations, etc.) on a set of governance objectives and norms, rules, practices, or implementation procedures and their attainment across multiple jurisdictions and levels of governance”. She underscores that they have developed a new hybrid governance in the multilateral system.¹¹¹⁵ This innovative model of governance is decentralized, networked, voluntary, and combines the public purpose of formal organizations with private practice.¹¹¹⁶

These partnerships introduce new features, including the introduction of new actors from the private and substate sectors to formulate and implement governance objectives in an international system designed by and for nation-states. In addition, it comprehends a collaboration between state and non-state actors, meaning joint decision-making concerning commonly identified or previously agreed objectives, to which partners assist with resources, knowledge, or claims of legitimacy.¹¹¹⁷

Therefore, public-private collaborations entail a redefinition of the scope of public and private authority across governance jurisdictions, yet they are always aimed at furthering public interests. The core characteristic that qualifies partnerships as a form of governance is the alignment towards a common public objective. This differentiates from the more traditional interactions between state and non-state actors, such as lobbying, shaming, consultation, and subcontracting.¹¹¹⁸

Although public-private partnerships occur within the multilateral system, they have a different organizational structure. The structure of these partnerships involves horizontal, nonuniversal, and reciprocal interactions, while the multilateral system is characterized by a legalized, bureaucratic organization that relies on intergovernmental agreements. Global public-private partnerships can be understood as networks that connect actors horizontally across jurisdictions and across levels of governance, from local to global.¹¹¹⁹

The main characteristic of these partnerships is that they are based on voluntary agreements, contrasting with the multilateral institutions established by and rooted in a system of international hard and soft laws. They are configured as network-based organizational

¹¹¹⁵ Liliana B Andonova, *Governance Entrepreneurs: International Organizations and the Rise of Global Public-Private Partnerships* (Cambridge University Press 2017) 2.

¹¹¹⁶ *ibid.*

¹¹¹⁷ *ibid.*, 7.

¹¹¹⁸ *ibid.*

¹¹¹⁹ *ibid.*, 9.

structures that involve horizontal, nonuniversal, and reciprocal interactions around a common goal.¹¹²⁰

It has been highlighted that the main benefits of GPPPs is that it brings together different sectors to address complex health issues, which no one sector can address on their own.¹¹²¹ In 2009, WHO underscored that public-private partnerships, in the context of global health, provide efficiency, equity, value for money, and support the achievement of positive outcomes in global health.¹¹²² At the same time, it has been identified that these PPPs have detrimental impacts such as high debt, high risk of PPPs, lack of accountability, and inequality impacts of PPPs.¹¹²³

3 Definition

Public-private partnerships for health have been described for the purpose of “‘bringing together a set of actors for the common goal of improving the health of populations based on mutually agreed roles and principles”.¹¹²⁴ In addition, in 2013 WHO declared that Public-Private Partnerships for Health are a “wide variety of ventures involving a diversity of arrangements, varying with regard to participants, legal status, governance, management, policy-setting prerogatives, contributions, and operational roles. They range from small, single-product collaborations with industry to large entities hosted in United Nations agencies or private not-for-profit organizations”.¹¹²⁵

In the literature, BUSE and WALT defined a global health PPPs as “a collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/or industry association) and an intergovernmental organization, so as to achieve a shared health-creating goal on the basis of a mutually agreed division of labor”.¹¹²⁶

¹¹²⁰ *ibid.*, 8.

¹¹²¹ Babacan, ‘Public–Private Partnerships for Global Health’ (n 1103).

¹¹²² *ibid.*

¹¹²³ For a detail analysis of the benefits of constraints of global health PPPs: Babacan, ‘Public–Private Partnerships for Global Health’ (n 1103).

¹¹²⁴ Buse and Walt, ‘Global Public–Private Partnerships: Part I’ (n 1097).

¹¹²⁵ World Health Organization, *Glossary of Globalization, Trade and Health Terms: Public-Private Partnerships for Health* (2013).

¹¹²⁶ Buse and Walt, ‘Global Public–Private Partnerships: Part I’ (n 1097).

Moreover, HAWKES described Public-Private Partnerships for Health as “an initiative established to address a health problem. In a PPP, the public and for-profit private sectors come together in some form to meet a shared goal via some degree of shared decision-making”.¹¹²⁷

BURCI specified PPS for health as “Designating long-term collaborative arrangements among a group of diverse stakeholders, some of which are of a public nature (e.g. governmental agencies and intergovernmental organizations) and others of a private nature (e.g. non-governmental organizations, private commercial companies, research institutes, professional associations, etc.) to jointly pursue a discreet public health goal”.¹¹²⁸

4 Legal framework

Global health public-private partnership generally rests on voluntary agreements such as memoranda of understanding or simply on public announcements without a necessarily formalized agreement that carries the force of international public law. Nonetheless, they are indirectly related to international normative or regulatory documents from which they frequently derive or justify their governance objectives.¹¹²⁹

In addition, the nonbinding and informal nature of these agreements lowers the political stakes for joining or leaving global partnerships, thereby increasing the chances of participation. This voluntary, self-selected involvement allows partnerships to be grounded in a set of shared norms, which are then strengthened and disseminated through the partnership’s network. This occurs via processes such as knowledge exchange, trust-building, social accountability, and practical implementation.¹¹³⁰

A few critical points began to appear in global health PPPs. Concerns about the public-private dichotomy remain central. The so-called “privatization of world politics” underscores that PPPs should be understood as a reconfiguration of the boundaries between the public and private spheres, reflecting a political effort to embed private interests more deeply within an “ever-shrinking public sphere”.¹¹³¹ In this sense, PPPs are integral to the ongoing neoliberalization of

¹¹²⁷ Hawkes, *High-Level Group Working Paper on Public-Private Partnerships for Health* (n 1099).

¹¹²⁸ Burci, ‘Public/Private Partnerships in the Public Health Sector’ (n 26).

¹¹²⁹ Andonova, *Governance Entrepreneurs* (n 1115) 9-10.

¹¹³⁰ *ibid.*

¹¹³¹ Ruckert and Labonté, ‘Public-Private Partnerships (PPPs) in Global Health’ (n 1098).

global health and its governance, serving as evolving expressions of neoliberal governance forms.¹¹³²

One of the most pressing issues is the delegation of public functions to philanthropic and private actors, raising significant accountability issues.¹¹³³ Unlike the public sector, where accountability mechanisms are generally subject to democratic oversight, private sector accountability follows different standards and is often less transparent.¹¹³⁴

CLARKE in her detailed scrutiny of GPPPs under international law, highlights the hybrid composition, comprising states and international organizations (with legal personality under international law), alongside entities such as corporations, NGOs, research institutes, and philanthropic foundations, which are interpreted as not having legal personality under international law.¹¹³⁵ As a result of this composition, the legal status of GPPPs under international law is unclear.¹¹³⁶

Applying the three traditional approaches used to assess international legal personality, the will of the states, the recognition approach, and the objective approach, CLARKE concludes that most GPPPs, including formal alliances like Roll Back Malaria and Stop TB, and separate entities, do not possess legal personality under international law.¹¹³⁷ However, notable exceptions include GAVI which have been granted legal personality under domestic law in Switzerland and the Global Fund, which is recognized as having legal personality under international law in Switzerland and the United States United States, and in countries such as Moldova, Montenegro, Rwanda, Eswatini, Ghana, Ethiopia, and Georgia.¹¹³⁸

A legal implication is that these partnerships cannot be held accountable under international law. CLARKE further argues that, while domestic legal systems might appear as alternative avenues for assigning responsibility, some GPPPs enjoy immunity from the jurisdiction of domestic courts in certain states. This combination of a lack of international legal status and immunity from domestic courts underscores a significant accountability gap.¹¹³⁹

¹¹³² *ibid.*

¹¹³³ Babacan, 'Public-Private Partnerships for Global Health' (n 1103).

¹¹³⁴ *ibid.*

¹¹³⁵ Lisa Clarke, 'Chapter 3' in Lisa Clarke, *Public-Private Partnerships and Responsibility under International Law* (Routledge 2014).

¹¹³⁶ *ibid.*

¹¹³⁷ *ibid.*

¹¹³⁸ Lisa Clarke, 'Chapter 8' in Lisa Clarke, *Public-Private Partnerships and Responsibility under International Law* (Routledge 2014).

¹¹³⁹ Lisa Clarke, 'Chapter 3' (n 1135).

Nevertheless, states retain their international human rights obligations, which extend to their engagement with public-private partnerships. This includes a duty to exercise due diligence in ensuring that such partnerships do not undermine the protection, respect, and fulfillment of human rights.

Thus, the issue of judicial review starts to appear here. Injured parties may struggle to identify whom to hold accountable. CLARKE concludes that state responsibility and the responsibility of international organizations under international law would be the best avenues to bridge the gap in responsibility under international law concerning the acts of global health public-private partnerships.¹¹⁴⁰

As mentioned above, there are different categories of GPPPs. Thus, to better understand the legal framework of this new format of PPPs, three examples of well-established and widely recognized GPPPs will be examined, highlighting the legal framework of each.

5 Examples

5.1 Global Alliance for Vaccine and Immunization

In 2000, the Global Alliance for Vaccine and Immunization (GAVI Alliance) was launched with an initial grant from the Bill and Melinda Gates Foundation.¹¹⁴¹ It is composed of the WHO, UNICEF, World Bank, donor governments, international development and finance organizations, the pharmaceutical industry, and representatives from developing countries.¹¹⁴² GAVI is considered a separate entity and is recognized as having legal personality under international law in Switzerland.¹¹⁴³

The main goal of the GAVI Alliance is to save lives and protect people's health by increasing the equitable and sustainable use of vaccines in low-income developing countries.¹¹⁴⁴ To achieve this purpose, GAVI facilitates the research and development of vaccines for the developing world and provides support in connection with achieving the foregoing purposes by

¹¹⁴⁰ For a detailed analysis of states and international organizations responsibility under international law see Lisa Clarke, 'Chapter 4 and 5' in Lisa Clarke, *Public-Private Partnerships and Responsibility under International Law* (Routledge 2014).

¹¹⁴¹ Gavi, 'About Our Alliance' (*Gavi*) <<https://www.gavi.org/our-alliance/about>> accessed 11 September 2023.

¹¹⁴² Katerini T Storeng, 'The Gavi Alliance and the "Gates Approach" to Health System Strengthening' (2014) 9 *Global Public Health* 865.

¹¹⁴³ Clarke, *Public-Private Partnerships and Responsibility under International Law* (n 1111).

¹¹⁴⁴ Gavi, 'About Our Alliance' (n 1141).

helping to strengthen health care systems and civil societies supporting such purposes in the developing world.¹¹⁴⁵ Currently, GAVI is a Swiss Foundation with international institution status in Switzerland.¹¹⁴⁶

GAVI Alliance recognized itself as an “innovative international public-private partnership” that brings together various organizations such as governments, United Nations organizations, vaccine manufacturers, foundations, nongovernmental organizations, and research institutes.¹¹⁴⁷

The statute of the GAVI Alliance has provisions about its financial means and organization. The governance, administrative, and advisory bodies of GAVI are the Board, the Secretariat, the Executive Committee, Auditors, Standing Board Committees and Advisory Committees.¹¹⁴⁸

Funding of GAVI works is done through two mechanisms, the Advance Market Commitment and the International Finance Facility for Immunisation.¹¹⁴⁹ The Advance Market Commitment incentivizes pharmaceutical companies to develop and produce vaccines by guaranteeing an affordable long-term price, backed by donor funding. The International Finance Facility for Immunisation ensures predictable resources by states long-term legally-binding commitments to donate funds and then borrows against these commitments and issues bonds on capital markets.¹¹⁵⁰ Additional funding comes from direct multi-year state contributions as well as private and philanthropic support.¹¹⁵¹

It must be highlighted that the applicable law is Swiss legislation,¹¹⁵² and the GAVI Alliance is created for an unlimited time.¹¹⁵³ Furthermore, the decision-making is made by the board which is composed of 18 members, including one seat for a representative of the World Health Organization; one seat for a representative of UNICEF; one seat for a representative of the World Bank; one seat for a representative of the Bill & Melinda Gates Foundation; five seats for representatives of implementing country governments; five seats for representatives of donor country governments; one seat for a representative of the vaccine industry industrialized

¹¹⁴⁵ *Gavi Alliance Statutes of 29 October 2008* (Last modified on 24–25 June 2020), 29th October 2008, OXIO 630.

¹¹⁴⁶ Gavi, ‘Governance and Legal Structures’ (*Gavi*) <<https://www.gavi.org/our-alliance/governance/legal-structures>> accessed 7 July 2025.

¹¹⁴⁷ *Gavi Alliance Statutes* (n 1145) art 3.

¹¹⁴⁸ *ibid*, art 8.

¹¹⁴⁹ Clarke, *Public-Private Partnerships and Responsibility under International Law* (n 1111).

¹¹⁵⁰ *ibid*.

¹¹⁵¹ *ibid*.

¹¹⁵² *Gavi Alliance Statutes* (n 1145) art 5.

¹¹⁵³ *ibid*.

countries; one seat for a representative of the vaccine industry developing countries; one seat for a representative of civil society; and one seat for a representative of technical health/research institutes.¹¹⁵⁴

5.2 The Global Fund, to fight AIDS, Tuberculosis, and Malaria

In 2002, the Global Fund was created as a response to AIDS, tuberculosis (TB), and malaria. A partnership among governments, civil society, technical agencies, the private sector, and people affected by the diseases, the Global Fund was established as a foundation under Swiss law.¹¹⁵⁵ Since its creation, more than US\$55.4 billion has been disbursed in the fight against HIV, TB, and malaria and for programs to strengthen systems for health across more than 155 countries.¹¹⁵⁶

The mission of the Global Fund is to ensure a healthier, safer, and more equitable future for all through attracting, managing, and distributing resources to support programs in the prevention of the three diseases mentioned above.¹¹⁵⁷ Moreover, it has an elaborate governance structure and operational approach that comprehends a board, secretariat, technical review panel, local fund agent, principal recipient, and country coordinating mechanism.¹¹⁵⁸

The Global Fund is considered a separate entity.¹¹⁵⁹ Originally, it was established as a foundation under Swiss law, and signed an Administrative Services Agreement with the WHO that provided the Secretariat for the Global Fund.¹¹⁶⁰ In 2004, it became recognized as having international juridical personality and legal capacity with privileges and immunities in Switzerland.¹¹⁶¹ Later, in 2006, it was designated a public international organization with privileges and immunities in the United States.¹¹⁶² In 2019, the Global Fund Agreement on Privileges and Immunities entered into force and as a result Global Fund now enjoys privileges and immunities in the ten countries that ratified the agreement (Eswatini, Ethiopia, Georgia, Liberia, Malawi, Moldova, Mozambique, Rwanda, Senegal, and Togo) in addition to the four

¹¹⁵⁴ *ibid.*, art 9, art 13 and art 15.

¹¹⁵⁵ Clarke, *Public-Private Partnerships and Responsibility under International Law* (n 1111) 29.

¹¹⁵⁶ The Global Fund to Fight AIDS, Tuberculosis and Malaria, 'History of the Global Fund' (*The Global Fund*) <<https://www.theglobalfund.org/en/about-the-global-fund/history-of-the-global-fund/>> accessed 13 September 2023.

¹¹⁵⁷ Clarke, *Public-Private Partnerships and Responsibility under International Law* (n 1111) 30.

¹¹⁵⁸ The Global Fund to Fight AIDS, Tuberculosis and Malaria, 'People and Structures' (*The Global Fund*) <<https://www.theglobalfund.org/en/about-the-global-fund/people-and-structures/>> accessed 13 August 2023.

¹¹⁵⁹ Burci, 'Public/Private Partnerships in the Public Health Sector' (n 26).

¹¹⁶⁰ Clarke, 'Chapter 2' (n 1149).

¹¹⁶¹ *ibid.*

¹¹⁶² *ibid.*

other countries (Switzerland, the United States, Uganda and Zimbabwe) that granted similar protections to the Global Fund under their domestic laws.¹¹⁶³

In 2018, the Global Fund to Fight AIDS, Tuberculosis and Malaria engaged in a partnership with the alcoholic beverage Heineken with the aim of fighting infectious diseases in Africa.¹¹⁶⁴ The idea of this collaboration was to use Heineken's extensive logistics and communications expertise to assist in delivering medical supplies on the continent. However, there was a lot of criticism about women from sexual exploitation and the perils caused by alcohol on people's health.¹¹⁶⁵ Thus, this already highlights concerns over conflicts of interest and commercial determinants of health, which it is intensified in PPPs for NCD prevention.

5.3 The Stop TB Partnership

In 2000, the Stop TB Partnership was founded and hosted by the WHO until 2014. Currently, the Stop TB Partnership Secretariat is hosted and administered by United Nations Office for Project Services in Geneva, Switzerland.¹¹⁶⁶ Its mission is to achieve a world free of tuberculosis by ensuring that everyone with TB has access to effective diagnosis, treatment, and cure, stopping transmission of TB, reducing the social and economic inequalities of TB, developing implementing, and increase access to new preventive, diagnostic and therapeutic TB tools, products, and strategies; and social mobilization.

The Stop TB Partnership classifies itself as a broad global partnership of over 2,000 partners, including TB communities, international and technical organizations, government programs, research and funding agencies, foundations, NGOs, society and community groups, and private sector companies.¹¹⁶⁷ The Stop TB Partnership is governed by the Board and supported by two

¹¹⁶³ The Global Fund to Fight AIDS, Tuberculosis and Malaria, 'Global Fund Agreement on Privileges and Immunities Enters into Force' (*The Global Fund* 2019) <<https://www.theglobalfund.org/en/news/2019/2019-04-17-global-fund-agreement-on-privileges-and-immunities-enters-into-force/>> accessed 25 June 2025.

¹¹⁶⁴ Babacan, 'Public-Private Partnerships for Global Health' (n 1103).

¹¹⁶⁵ The partnership was suspended mainly because of the sexual exploitation issue and for the issue of alcohol being dangerous to health and one of the risk key factor for developing NCDS. The Global Fund to Fight AIDS, Tuberculosis and Malaria, 'Global Fund Suspends Partnership with Heineken' (*The Global Fund* 2018) <<https://www.theglobalfund.org/en/news/2018/2018-03-29-global-fund-suspends-partnership-with-heineken/>> accessed 13 September 2023.

¹¹⁶⁶ Stop TB Partnership, 'How the Partnership Works' (*Stop TB*) <<https://www.stoptb.org/who-we-are/how-partnership-works>> accessed 13 September 2023.

¹¹⁶⁷ Stop TB Partnership, 'Our Journey' (*Stop TB*) <<https://www.stoptb.org/stop-tb-partnership/our-journey>> accessed 13 September 2023.

standing Board committees: the Executive Committee and the Finance Committee. The decision-making is made by the board.¹¹⁶⁸

There is also the Secretariat, which is based in Geneva and facilitates the work of the board and overall partnership as determined by its board-approved operational strategy. The Secretariat is led by an Executive Director and is hosted by United Nations Office for Project Services, which provides administrative and hosting services, as it does not have its own legal status. Moreover, it comprises working groups, which are platforms for communication to inform and promote policies and guidelines in support of the implementation of the Global Plan to end TB.¹¹⁶⁹

The Stop TB is considered a formal partnership or alliance and do not have legal personality under international law.¹¹⁷⁰ Thus, does not have the capacity to contract, to acquire and dispose of immovable and movable property or to institute legal proceedings. In this case, the WHO, as host, acts on its.¹¹⁷¹

6 New format of global health public-private partnerships

It can be affirmed that the global public-private partnerships began to focus on infectious diseases, such as the examples of GAVI Alliance, Stop Malaria, etc. Nevertheless, over the years, they have expanded to other areas. For instance, to improve the nutrition of vulnerable populations in developing countries. The World Food Programme (WFP) was created in 1961 as an experiment to provide food aid through the UN system.¹¹⁷² Nowadays, the WFP, in cooperation with the private sector, aims to achieve SDG 2 (zero hunger) in over 120 countries (mainly in Africa, Latin America, the Middle East, and the Asia-Pacific islands).¹¹⁷³

The World Food Programme is considered a humanitarian organization that works in areas such as food fortification, food safety and quality, food systems, and nutrition.¹¹⁷⁴ Grounded in the Agenda 2030, WPF recognizes the vital role of partnerships and, therefore, works with

¹¹⁶⁸ Stop TB Partnership, 'The Board' (*Stop TB*) <<https://www.stoptb.org/who-we-are/board>> para 17.4, accessed 7 July 2023.

¹¹⁶⁹ *ibid.*

¹¹⁷⁰ Lisa Clarke, 'Chapter 3' (n 1135).

¹¹⁷¹ Clarke, 'Chapter 2' (n 1149).

¹¹⁷² World Food Programme, 'History' (*WFP*) <<https://www.wfp.org/history>> accessed 28 November 2023.

¹¹⁷³ World Food Programme, 'Where We Work' (*WFP*) <<https://www.wfp.org/countries>> accessed 28 November 2023.

¹¹⁷⁴ World Food Programme, 'Who We Are' (*WFP*) <<https://www.wfp.org/who-we-are>> accessed 28 November 2023.

governments, other UN agencies, NGOs, and private companies to mobilize resources and find innovative solutions.

It is noteworthy to mention that PepsiCo Foundation and Yum! Brands (which includes brands such as KFC, Pizza Hut, and Taco Bell) are among the partners.¹¹⁷⁵ One must question the credibility of these brands as partners to guarantee food safety and nutrition. It is true that here, the focus has been on improvements to malnutrition (meaning undernutrition), nonetheless, the issue of conflict of interest of food corporations that sell unhealthy products linked to diet-related NCDs began to emerge.

Global Alliance for Improved Nutrition

In 2002, the UN launched the Global Alliance for Improved Nutrition (GAIN), a Swiss-based foundation that works with governments, businesses, and civil society, and it declares that “everyone in the world should have access to nutritious, safe, and affordable food. Today, one in three people - drawn from nearly every country on the planet - are unable to consume enough nutritious food”.¹¹⁷⁶

The Vision of GAIN is “Healthier diets for all people,” and it aims to improve the consumption of healthier diets for all people through nutritious and safe foods and the reduction of unhealthy and unsafe food consumption.¹¹⁷⁷ GAIN establishes partnerships with global food and beverage industries to stimulate market-based solutions that address malnutrition, produce commercial benefits for companies, and encourage economic development in low- and middle-income countries.¹¹⁷⁸

GAIN declares that it only partners with those organizations whose values and approaches are consistent with its own, and through GAIN’s Principles of Engagement, it makes a thorough review before establishing a formal partnership.¹¹⁷⁹ GAIN establishes that it will not work with organizations that have breached its policies for the safeguarding of vulnerable persons,

¹¹⁷⁵ World Food Programme, ‘Our Private Sector Partners’ (*WFP*) <<https://www.wfp.org/partners/private-sector>> accessed 28 November 2023.

¹¹⁷⁶ Global Alliance for Improved Nutrition, ‘About’ (*GAIN*) <<https://www.gainhealth.org/about>> accessed 28 November 2023.

¹¹⁷⁷ Global Alliance for Improved Nutrition, ‘Vision and Mission’ (*GAIN*) <<https://www.gainhealth.org/about/vision-and-mission>> accessed 28 November 2023.

¹¹⁷⁸ Vivica I Kraak and others, ‘Balancing the Benefits and Risks of Public–Private Partnerships to Address the Global Double Burden of Malnutrition’ (2011) 15 *Public Health Nutrition* 503.

¹¹⁷⁹ Global Alliance for Improved Nutrition, ‘Partnerships’ (*GAIN*) <<https://www.gainhealth.org/about/partnerships>> accessed 2 October 2023.

produced armaments, tobacco, or pornography, extracted natural resources in harmful ways, use child labor, or have violated the International Code of Marketing of Breast-milk Substitutes in the last 5 years.¹¹⁸⁰

Taking into account that GAIN’s vision is that all people have access to and consume nutritious and safe food, it is curious to note that no mention of ultra-processed industries exists. Moreover, Unilever, which includes brands such as Ben & Jerry’s, is one of the donors of GAIN.¹¹⁸¹

Additionally, concerns have been raised that GAIN’s technological and pro-business orientation resulted more to creating new markets for participating firms rather than advancing the broader humanitarian goal of addressing undernutrition around which it was originally framed.¹¹⁸²

Scaling Up Nutrition

Another example of the UN framework is the Scaling Up Nutrition (SUN). The SUN was established in 2010 with the goal of ending malnutrition through collaborative work from civil society, the United Nations, donors, businesses, researchers, and governments of SUN Countries.¹¹⁸³

The SUN recognizes itself as a “country-driven initiative”, but under the UN Global registry of voluntary commitments and multi-stakeholder partnerships, the SUN can be classified as a partnership.¹¹⁸⁴ Moreover, its structures and functions would fall under the category of global public-private partnerships.¹¹⁸⁵

The SUN has been focused on raising global attention to the issue of child malnutrition and has established 10 principles of engagement, including “be transparent about impact”. Principle 2 highlights that the SUN Movement is open to all stakeholders who demonstrate their

¹¹⁸⁰ Global Alliance for Improved Nutrition, ‘Policies’ (*GAIN*) <<https://www.gainhealth.org/about/policies>> accessed 2 October 2023.

¹¹⁸¹ Global Alliance for Improved Nutrition, ‘Donors’ (*GAIN*) <<https://www.gainhealth.org/about/donors>> accessed 2 October 2023.

¹¹⁸² Stevenson, ‘The Relevance of the Public–Private Partnership Paradigm’ (n 1019).

¹¹⁸³ Scaling Up Nutrition, ‘The History of the SUN Movement’ (*Scaling Up Nutrition*) <<https://scalingupnutrition.org/about/what-we-do>> accessed 5 October 2023.

¹¹⁸⁴ Ann Louise Lie, “‘We Are Not a Partnership’ – Constructing and Contesting Legitimacy of Global Public–Private Partnerships: The Scaling up Nutrition (SUN) Movement’ (2021) 18 *Globalizations* 19.

¹¹⁸⁵ *ibid.*

commitment to its goals and principles. However, it has a remark concerning the engagement with breast-milk substitute companies.¹¹⁸⁶ Nevertheless, multinational food and sweetened beverage corporations that also undermine efforts to improve nutrition are not excluded from the movement.¹¹⁸⁷

This new model of global partnerships, primarily focused on addressing undernutrition in developing countries, already raises significant concerns about the conflict of interest between multinational food corporations and public health initiatives (the alignment of these industries to the public health goal). Nonetheless, the complexities escalate when it comes to partnerships between these multinational food corporations and public authorities with the aim of advancing public health promotion and NCD prevention.

IV Comparative analysis: Global health PPPs vis-à-vis the PPPs in general

Considering the two aforementioned formats of public-private partnerships, it is possible to establish a comparative assessment of their fundamental criteria. Both types of PPPs are rooted in neoliberal ideas that emphasize the perceived inefficiency of the state in delivering public goods and services, promoting private sector solutions. This rationale drives both forms of PPPs to blur the boundaries between the public and private spheres, highlight longstanding debates, also prominent in privatization discussions, about the growing role of private actors in delivering public services or even exercising public functions.

Global health PPPs have maintained some aspects from the original PPP framework. For instance, the voluntary nature, the shared decision-making component, and a clear common goal to be achieved. Nevertheless, GPPPs have a specific focus: the development of drugs and vaccines, and enhancing access to medicines in low-income nations. More recently, they have also taken on the task of improving nutrition for vulnerable populations in developing countries. This unique focus has led to the involvement of intergovernmental organizations as partners, introducing a novel characteristic to PPPs.

The original format of PPPs most commonly occurs between a government and a private actor in a specific country to construct infrastructure projects, such as a hospital. On the other hand,

¹¹⁸⁶ “violators of the International Code of Marketing of Breast-milk Substitutes undermine efforts to improve nutrition” and therefore are excluded from the movement. Scaling Up Nutrition, ‘The History of the SUN Movement’ (n 1183).

¹¹⁸⁷ Lie, “‘We Are Not a Partnership’” (n 1184).

global health PPPs represent a more complex system involving multiple partners, such as governments, private industries, and intergovernmental organizations.

Still, the global health PPPs adhere to the overarching paradigm of the original format as an “innovative tool” characterized by a high degree of institutionalization. Concerning the legal framework, global health PPPs often have statutes that establish the applicable law and clearly delineate the roles and responsibilities of each partner. However, due to their hybrid composition, they generally lack legal personality, which complicates matters of judicial review. This differs from traditional PPPs, in which, depending on the contract established, have defined avenues for legal recourse.

From a human rights perspective, both types of PPPs highlight the state’s obligation to human rights. In GPPPs mainly to the right to health and the right to life, while PPPs in the relevant rights can vary and may include the rights to health, education, life, a healthy environment, and others. Although private actors do not have direct human rights obligations, instruments such as the UN Guiding Principles on Business and Human Rights underscore elements of responsibility of business and also the state’s oversight authority.

Finally, both types of partnerships have a legal framework delimiting the roles of the public and the private sector, and their relationships demarcating the spheres of cooperation, which is firmly established. However, it is mostly nonexistent when applied to PPPs focused on NCD prevention.

CHAPTER 10: PUBLIC-PRIVATE PARTNERSHIPS FOR NCD PREVENTION

I Terminology

There have been some attempts to define the different types of engagement between public authorities and the food industry in the context of NCD prevention. In the literature, these “public-private partnerships” appear in different terms.¹¹⁸⁸ For example, voluntary agreements, stakeholder or multistakeholder engagement, multistakeholder partnerships, collaborations between the public and the private sector, whole-of-society approach, or “all of society approach”, alliances, and platforms, for participatory governance, cross-sectoral collaboration, and public-private engagement. A detailed analysis will be provided next. For the purpose of clarification, this thesis will adopt the term PPPs for NCD prevention.

1 Historical framework

On the same note as what occurred in the scenario of GPPPs, the idea that no sector can tackle the challenges imposed by non-communicable diseases alone has been widely embraced. In 2006, the public health commissioner of the European Union declared, “You cannot legislate on what people eat. You have to form public-private partnerships. We are all... part of the problem and are all part of the solution”.¹¹⁸⁹ Moreover, at the international level, there have been repeated calls for the engagement of the private industry in the instruments related to NCD prevention and unhealthy diets.¹¹⁹⁰ At the regional level, the “Obesity Prevention White Paper” has encouraged partnerships with the private sector, including the food industry, to tackle nutrition, overweight, obesity, and related health problems.¹¹⁹¹

Moreover, scholars have emphasized that in the context of NCD prevention, the central issue is not whether private industry will be involved, but rather the terms of that engagement.¹¹⁹²

¹¹⁸⁸ On a critical tone to the terminology Jonathan Marks argued that the term itself does not say much about the arrangement, meaning that does not indicate, for example, what each actor contributes to the collaboration or what will be the anticipated outcome. Jonathan H Marks, *The Perils of Partnership: Industry Influence, Institutional Integrity, and Public Health* (Oxford University Press 2019) 122.

¹¹⁸⁹ Rory Watson, ‘European Health Commissioner Praises Food Firms for Efforts to Cut Obesity’ (2006) 333 BMJ 1036.

¹¹⁹⁰ Part 2, Chapter 5, V.

¹¹⁹¹ Part 2, Chapter 6, II, 2.

¹¹⁹² Thomas and Gostin, ‘Tackling the Global NCD Crisis’ (n 29).

Additionally, unlike tobacco, the different legal treatment of the food industry is often attributed to the greater regulatory challenges it presents, since food is a fundamental necessity.¹¹⁹³

Furthermore, the perceived shortcomings of the traditional command-and-control approach and within the “new governance” framework, which aspires to be more open-textured, participatory, bottom-up, consensus-oriented, contextual, flexible, integrative, and pragmatic, new regulatory tools emerged.¹¹⁹⁴ Additionally, it has been highlighted that under neoliberalism ideals, states have limited public regulation and increasingly turned to PPPs as a preferred governance mechanism.¹¹⁹⁵

Thus, a combination of soft law global health instruments encouraging private sector involvement, the limited application of command-and-control regulations at the domestic level, the rise of “new governance” regulatory tools, persistent antipaternalistic critiques emphasizing “individual autonomy,” the perceived challenges of regulating food industries because food is tied to life’s necessities, and the belief in the value of private sector expertise on their (unhealthy) products have all contributed to the conditions for the adoption of PPPs as an innovative alternative regulatory approach for NCD prevention.

2 Key characteristics

PPPs for NCD prevention have significant differences from global health PPPs. One of the main differences that have been identified between the GPPPs and PPPs for NCD prevention is that the former delivers a public service, and the PPPs for NCDs aim at public health promotion. The Ottawa Charter for Health Promotion defines health promotion as “the process of enabling people to increase control over, and to improve their health”.¹¹⁹⁶ Exploring further, public health promotion englobes social and environmental initiatives that facilitate the adoption of healthy behaviors (including health literacy, healthy public policies, and changes in the physical environment).¹¹⁹⁷ Finally, the Ottawa Charter establishes that the fundamental conditions and

¹¹⁹³ *ibid.*

¹¹⁹⁴ Gostin and Wiley, *Public Health Law: Power, Duty, Restraint* (n 353) 207.

¹¹⁹⁵ Jennifer Clapp and Gyorgy Scrinis, ‘Big Food, Nutritionism, and Corporate Power’ (2017) 14 *Globalizations* 578.

¹¹⁹⁶ World Health Organization, *The Ottawa Charter for Health Promotion* (1986).

¹¹⁹⁷ Lucy A Parker, Gustavo A Zaragoza and Idefonso Hernández-Aguado, ‘Promoting Population Health with Public-Private Partnerships: Where’s the Evidence?’ (2019) 19 *BMC Public Health*.

resources for health are: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity.¹¹⁹⁸

Since the Ottawa Charter, health promotion has been one of the core features of public health.¹¹⁹⁹ The Fourth International Conference on Health Promotion, through the Jakarta Declaration on Leading Health Promotion, declared the necessity of surpassing traditional boundaries between the public and private sectors, calling for cooperation through new partnerships for health.¹²⁰⁰

On the other hand, public service is understood as “an activity performed to or for the benefit of the general public or the public good or otherwise in the public interest(...)”¹²⁰¹ Thus, the GPPPs assisting in research and the development of drugs and vaccines for infectious diseases would be improving a health service whereas PPPs for NCD prevention would target to change the social and environmental determinants of health to support population health enhancement.¹²⁰² However, from a critical analysis, one can argue that public service includes public health promotion. If public health is interpreted as a public good, then PPPs for NCD prevention would also fit in the traditional definitions of PPPs. Increasingly, has been argued to acknowledge health as a public good.¹²⁰³ Along the same lines, public service includes an activity performed to or for the benefit of the general public (...) or in the public interest. How can public health promotion not be linked to the benefit of the general public or the public interest?

¹¹⁹⁸ WHO, *The Ottawa Charter* (n 1196).

¹¹⁹⁹ It is imperative to differentiate health promotion from health education. Health education is related to the provision of health information and knowledge to individuals and communities with the finality to enable individuals to adopt healthy behaviors voluntarily. Whereas health promotion has a broader perspective taking a comprehensive approach to promoting health by involving various players and focusing on multisectoral approaches.

¹²⁰⁰ World Health Organization, *Jakarta Declaration on Leading Health Promotion into the 21st Century* <<https://www.who.int/teams/health-promotion/enhanced-wellbeing/fourth-global-conference/jakarta-declaration>> accessed 29 September 2023.

¹²⁰¹ UNECE, *Document ECE/CECI/WP/PPP/2022/5* (n 1062).

¹²⁰² Parker, Zaragoza and Hernández-Aguado, ‘Promoting Population Health with Public-Private Partnerships’ (n 1197).

¹²⁰³ Salma M Abdalla and others, ‘Claiming Health as a Public Good in the Post-COVID-19 Era’ (2020) 63 *Development*; Sandro Galea, ‘Public Health as a Public Good’ (*BU Edu* 2016) <<https://www.bu.edu/sph/news/articles/2016/public-health-as-a-public-good/>> accessed 7 July 2025.

Ambiguity of the term

In 2023, the book “Noncommunicable Diseases: A Compendium” was published, which has a chapter dedicated to “the role of public–private partnerships in NCD prevention and control”.¹²⁰⁴ Here, a public-private partnership has been described as a “collaborative organizational structure in which public, private, and/or nonprofit partners agree to share risks, resources and decision-making authority and responsibility.”¹²⁰⁵ Exploring the conceptualization, the book calls attention that the public and private sectors can engage in various formats, from contracts to simple dialogues. However, it highlights that the main characteristic of PPPs is the sharing of decision-making authority.¹²⁰⁶

Already in 2011, scholars have called attention to the need to clarify the term “partnership” between the public health sector and the food industry.¹²⁰⁷ Back then, these partnerships were described as a “mélange of interactions involving a range of different activities, from education campaigns to joint research activities, and a range of processes and structures for interaction”.¹²⁰⁸ A key element used to differentiate the interaction between the public health sector and the food industry is the shared decision-making power among partners. A true partnership would be when both sectors have a voice in shared decision-making, which implies that the private and public sectors take part in decisions about the initiative’s agenda, goals, strategies, resources, roles, and responsibilities.¹²⁰⁹ Whereas in “participation” based initiatives, there is mutual support, but no shared decision-making. Hence, shared decision-making can be considered one key element for the concept of public-private partnerships.

Later in 2016, different authors again emphasized the term’s lack of clarity. It has been pointed out that partnership has been used inaccurately to refer to any relationship, including governments, multilateral institutions, and industries. Hence, it would be considered a partnership when the actors involved have the same status.¹²¹⁰

HERNANDEZ-AGUADO and ZARAGOZA define PPPs in the scope of NCDs as public-private partnerships in health promotion.¹²¹¹ Drawing on the definition of the UN General Assembly

¹²⁰⁴ Alan M Trager and others, 'Chapter 57' in Nick Banatvala and Pascal Bovet (eds), *Noncommunicable Diseases: A Compendium* (Routledge 2023).

¹²⁰⁵ *ibid.*

¹²⁰⁶ Alan M Trager and others, 'Chapter 57' (n 1204).

¹²⁰⁷ Hawkes and Buse, 'Public Health Sector and Food Industry Interaction' (n 25).

¹²⁰⁸ *ibid.*

¹²⁰⁹ *ibid.*

¹²¹⁰ Ildelfonso Hernandez-Aguado and GA Zaragoza, 'Support of Public–Private Partnerships in Health Promotion and Conflicts of Interest' (2016) 6 *BMJ Open*.

¹²¹¹ *ibid.*

from 2003 the authors add that PPP has been used to describe various sorts of interaction involving a variety of actors and goals and delimited that these PPPs would be “agreements of which the objective is health promotion, understood as the process of enabling people to increase control over and to improve their health”.¹²¹² Moreover, PARKER, HERNANDEZ-AGUADO, and ZARAGOZA considered PPPs the initiatives where the interaction between private and public partners has been established for the “specific purpose of implementing or driving forward a health promotion program with a shared goal, thus excluding other types of interaction such as dialogue preceding regulation”.¹²¹³

Funding and governance

Additional factors contribute to the uncertainty surrounding the definition of a public-private partnership in the context of NCD prevention. For instance, funding mechanisms can take different forms. It can be funded by the government, and in other cases it is funded by industry, or even in some cases it involves joint funding.¹²¹⁴ Here also, the UN Standing Committee on Nutrition (SCN) classified it as direct funding, contributions in kind (goods or services), dialogue (including information exchange), and joint delivery.¹²¹⁵

In addition, the interactions can be led by public actors, others by the food industry. In some cases, large transnational companies are included; at other times, a smaller local business.¹²¹⁶

A governance typology was developed to guide policymakers in considering a public-private engagement for the nutrition sector. The domains developed are crucial to better understanding the partnerships in analysis. The described public-private engagement (PPE) “alludes to the formal and informal governance processes through which state and non-state actors collectively work to design, promote, maintain, and implement regulation”.¹²¹⁷

The engagement of the food industry and civil society can take different formats. The form can be established through information provision, consultation, direct involvement, collaboration,

¹²¹² *ibid.*

¹²¹³ Parker, Zaragoza and Hernández-Aguado, ‘Promoting Population Health with Public-Private Partnerships’ (n 1197).

¹²¹⁴ Corinna Hawkes and Kent Buse, ‘Public-Private Engagement for Diet and Health: Addressing the Governance Gap’ (UNSCN 2011).

¹²¹⁵ Marks, *The Perils of Partnership* (n 1188) 13.

¹²¹⁶ Hawkes and Buse, ‘Public-Private Engagement for Diet and Health’ (n 1214).

¹²¹⁷ Patay and others, ‘Fifty Shades of Partnerships’ (n 35).

and empowerment.¹²¹⁸ Mostly, PPE occurs through direct involvement where stakeholders are directly engaged in the discussion with their concerns being considered and incorporated in the policy design. Nevertheless, policymakers will make the decisions. And through collaboration, in which stakeholders and policymakers make decisions together. For instance, the UK Public Health Responsibility Deal is characterized by the collaboration between government and food industry actors in developing voluntary measures to improve the population's diet.¹²¹⁹

The degree of participation in formal decision-making has a significant impact on the institutional power granted by the PPE. Moreover, the stage of the policy cycle influences the power exercised by the stakeholders. For example, engagement can occur during the policy formulation, implementation, monitoring, and evaluation.¹²²⁰

Another critical factor is the type of food industry actor engaged. The governance typology for public-private engagement classified the food industry actors based on the following aspects: product portfolios for profit, size, and function.¹²²¹ First, the product portfolios for profit, which it would be crucial to understand whether the institutional power created through the PPE might be used to weaken public health goals.¹²²² For instance, industries that profit from manufacturing ultra-processed food and sweetened beverages probably have different motivations and interests in engaging in a PPE in relation to companies that profit primarily from the sales of healthy food items.¹²²³ This classification is highly relevant to avoid conflict of interest.

Second, the size of the industry can represent its economic power. Micro-, small-, and medium-sized enterprises, large local enterprises, and transnational businesses differ in the influence exercised over markets and government. Transnational corporations are considered powerful actors in the food system, thus influencing the achievement of public health goals.¹²²⁴

Furthermore, the function of the food industry can be divided into producers, manufacturers, distributors (including importers), and retailers.¹²²⁵ The main industry actor involved in PPE has been manufacturers. The core characteristics of these actors are their expertise, network,

¹²¹⁸ *ibid.*

¹²¹⁹ *ibid.*

¹²²⁰ *ibid.*

¹²²¹ *ibid.*

¹²²² *ibid.*

¹²²³ *ibid.*

¹²²⁴ *ibid.*

¹²²⁵ *ibid.*

and structural power. Through food formulation practices, manufacturers shape population diets.

Business models and classifications

Still trying to delimit the forms of engagement with the private sector, one method referencing the complexity level has been used. Rooted in a continuum, the different forms would be donations, sponsorship, alliances, and partnerships. Beginning with donation, which would increase each partner's brand image, then platforms for discussion created to share information and expertise without a governance structure.¹²²⁶ In the middle would be sponsorship that would be represented by monetary or in-kind payment or contribution to an event, activity, or individual that promotes a company's name, brand, products, or services.¹²²⁷ The following would be alliances, which are groups of organizations that combine forces to address specific public health issues through informal agreements. And at the higher level of complexity would be the partnerships, described as mechanisms based on shared decision-making that bring together a diversity of skills and resources of various organizations in innovative ways to improve specific outcomes.¹²²⁸ Along the same lines, partnerships have been described on a continuum ranging from networking to coordination, cooperation, and collaboration.¹²²⁹

Moreover, a different classification has been proposed for three types of partnerships: philanthropic, transactional, and transformative.¹²³⁰ A philanthropic partnership is when a company gives a charitable financial or food donation to an NGO, which can occur by an anonymous or acknowledged donation accompanied by media coverage for each partner. This comprises a low level of engagement between the parties. On the other hand, transactional partnerships encompass higher levels of interaction and resource investments. These are developed to advance each partner's agenda through compatibility among organizational values, missions, and goals through a mutually beneficial relationship. For instance, there can be co-branded sponsorships. Finally, transformational partnerships comprehend a higher degree of engagement, resource investment, managerial complexity, and relationships built over time

¹²²⁶ Collins, Mikkelsen and Axelrod, 'Interact, Engage or Partner?' (n 650).

¹²²⁷ *ibid.*

¹²²⁸ *ibid.*

¹²²⁹ Kraak and others, 'Balancing the Benefits and Risks of Public-Private Partnerships' (n 1178).

¹²³⁰ *ibid.*

to mutually influence the institutional cultures and practices of each partner. They have many partners to stimulate large-scale social or policy changes.¹²³¹

Finally, TRAGER presents four PPP business models.¹²³² PPPs for NCD prevention would be the business model for “developing a market for healthy goods and services” that is represented by a partnership between the government and food and beverage industries to provide healthier food and drink options through reformulation.¹²³³

Categories based on the core activities of the PPP

As in the case of global health public-private partnerships, the literature describes classifications for PPPs for NCD prevention based on their purpose. HAWKES has divided into five different categories.¹²³⁴

First, the core activity of the partnership can be public education. These are related to education and training. The main examples would be in the form of promoting nutrition to the public, especially children. For instance, cooking and growing skills in the Health4schools PPP and nutrition education in EPODE in France.¹²³⁵

Secondly, partnerships may be oriented to develop or improve products. This primarily includes initiatives such as food reformulation, which aims to reduce salt in food products, among other objectives. It also comprehends private-led commitments to expand company portfolios of more nutritious products and research-driven public-private partnerships focused on developing foods to combat obesity.¹²³⁶

Another category would be providing, distributing, or improving access to a product, for instance, delivering and providing fruits and vegetables.¹²³⁷ Furthermore, partnerships can be

¹²³¹ *ibid.*

¹²³² Alan M Trager and others, 'Chapter 57' (n 1204). The other business models described include partnerships between government and private-sector employers to provide workplace wellness programs such as workplace physical activity programmes, gym memberships; Gavi, the Vaccine Alliance, a partnership of funders (governments and donors) and the pharmaceutical industry, and Traditional PPP models for healthcare infrastructure and services.

¹²³³ Alan M Trager and others, 'Chapter 57' (n 1204).

¹²³⁴ Other authors have also classified PPPs based on the focus of engagement which are very similar of the categories presented by Corinna Hawkes. For instance, see Patay and others, 'Fifty Shades of Partnerships' (n 35).

¹²³⁵ Hawkes, *High-Level Group Working Paper on Public-Private Partnerships for Health* (n 1099).

¹²³⁶ *ibid.*

¹²³⁷ *ibid.*

focused on developing commercial marketing materials to promote or inform about a product or service, or as an aspect of that product.¹²³⁸

Finally, the partnership's goal can be to improve the regulation of some aspects of a product, including industry commitment to changing its practices of marketing food to children.¹²³⁹

Credible partners

There have been many attempts to define who is a credible partner to establish these collaborations. For instance, a study published by the “PPP Initiative” used as a Background Paper for Working Group 3 of the World Health Organization Independent High-level Commission on NCDs explores potential business models that involve private sector support for national responses in preventing and controlling NCDs. This study categorizes industries according to value alignment with public health goals.¹²⁴⁰ The values of the food and beverage industries were considered to be “potentially aligned” with the public sector, meaning that changes to their goods and services could lead to an increase in health, for instance, the reformulation of products to meet healthier standards.¹²⁴¹ On the other hand, tobacco and the gun industry are examples of misalignments because the increase in demand for their goods and services leads to a decrease in health.¹²⁴²

Along the same lines, partnerships with the ultra-processed food and sweetened beverage industries have been described as “possible partnerships with caveats” with the condition that the industry and corporate interests do not override public health interests. Here, the author classifies the food industry at the same level as the pharmaceutical industry.¹²⁴³

On the scope of children, there is a safeguard concerning engagement with companies' practices not compliant with the International Code of Marketing of Breast-milk Substitutes. The issue of conflict of interest and the breast-milk substitutes industry has been widely exposed.¹²⁴⁴

¹²³⁸ *ibid.*

¹²³⁹ *ibid.*

¹²⁴⁰ Alan M Trager, *Potential Business Models that Involve Private Sector Support for National Responses in Preventing and Controlling NCDs*, Background Paper for Working Group 3, World Health Organization Independent High-level Commission on NCDs.

¹²⁴¹ *ibid.*

¹²⁴² *ibid.*

¹²⁴³ Vera Luiza da Costa e Silva and others, ‘O Risco de Parcerias Público-Privadas Em Saúde Pública Pode Ser Classificado?’ (2017) 33 *Cadernos de Saúde Pública*.

¹²⁴⁴ Phillip Baker and others, ‘The Political Economy of Infant and Young Child Feeding: Confronting Corporate Power, Overcoming Structural Barriers, and Accelerating Progress’ (2023) 401 *The Lancet* 503.

While collaborations with industries producing sweetened beverages and highly processed foods also raise similar concerns about credibility and effectiveness in public health efforts, these industries are still considered “credible partners” for engagement in such partnerships.

Formal aspects

In order to adopt a definition of PPPs for NCD prevention, it is crucial to determine the parts involved in these collaborations. Here, the “public” part should be understood as a government authority, whereas the “private” part is represented by the “business sector”, meaning the for-profit private sector, encompassing commercial enterprises such as the food and sweetened beverage industries.

Furthermore, to develop a definition, what does not constitute a PPP must be clear. PPPs for NCD prevention are not the same as corporate social responsibility. CSR is a voluntary code of conduct and therefore lacks one of the main elements of a PPP, which is the public partner. Along the same lines, public-private partnerships are different from self-regulation. Industry self-regulation, which has been used a lot in the context of marketing unhealthy food to children, also lacks the public partner requirement, consequently not constituting a PPP.

In addition, there have been arguments that PPPs should not be seen as synonyms for “multistakeholder partnerships”, “multistakeholder initiatives” or “multistakeholder dialogues” because these initiatives include civil society and not necessarily include governments or international agencies.¹²⁴⁵ In contrast, PPPs include government agencies but do not necessarily include civil society as partners.¹²⁴⁶

However, it is plausible to argue that PPPs for NCD can include civil society as partners. For instance, the Public Health Responsibility Deal, which can be considered the major example of PPPs for NCDs, was a partnership between the government, the corporate sector, academia, and voluntary organizations.¹²⁴⁷ Likewise, looking into the UN Sustainable Development Goals, SDG 17 “Partnerships for the goals” includes a subtitle, multi-stakeholder partnerships, which comprises target 17.17 Encourage and promote effective public, public-private and civil society partnerships, building on the experience and resourcing strategies of partnerships”. Therefore, PPPs for NCD do not necessarily exclude civil society. To support this argument, it

¹²⁴⁵ Hawkes, *High-Level Group Working Paper* (n 1235).

¹²⁴⁶ *ibid.*

¹²⁴⁷ For a detailed analysis of the Public Health Responsibility Deal see Chapter 10, II, 1.

has been described that some public-private partnerships are established exclusively between institutions of the state and the private sector, while others include civil society as well.¹²⁴⁸

3 Definition

Preliminary remarks

Hence, this research adopts the following definition: public-private partnerships for NCD prevention are voluntary collaborations between the public sector (government entities) and the for-profit private sector (corporate sector/business) to address the challenges imposed by NCDs with the common aim of public health promotion via some degree of shared decision-making. They might include other partners, such as nonprofit partners or civil society. The interaction can occur in different formats: public education and information, product reformulation, research, access to healthy foods, and control of advertising, marketing, and promotion.

It is imperative to scrutinize certain elements within this definition closely. First, the key aspect of this collaboration is its voluntary nature. Secondly, the for-profit private sector to be considered here is multinational food corporations, predominantly represented by the ultra-processed food/sweetened beverage industries. These industries possess the intrinsic challenging characteristic of developing risk-creating products that contribute to the high rates of NCDs.¹²⁴⁹

In addition, with reference to PARKER, HERNANDEZ-AGUADO, and ZARAGOZA's observations, the interaction must explicitly aim to implement or advance a health promotion program with a common objective.¹²⁵⁰ Therefore, participants mutually commit to working together to achieve a common purpose or to undertake a specific task related to public health promotion.

The element "common aim" and "public health promotion" raise issues here. While the government is focused on promoting public health and improving the population's overall health, the food and sweetened beverage industries do not share this objective. Multinational

¹²⁴⁸ Hawkes and Buse, 'Public-Private Engagement for Diet and Health' (n 1214).

¹²⁴⁹ For instance, sweetened beverages full of sugar that is linked to obesity and consequently diabetes and other NCDs.

¹²⁵⁰ Parker, Zaragoza and Hernández-Aguado, 'Promoting Population Health with Public-Private Partnerships' (n 1197).

food corporations are primarily driven by profit maximization.¹²⁵¹ This profit-centered approach limits their motivation to actively promote public health. However, one could argue that current market pressures are encouraging companies to adopt more “acceptable” practices that align better with public expectations.

The element of shared decision-making may or may not be present in this type of partnership. This will depend on how the PPP is established, specifically, whether the targets are predetermined and, if so, who is responsible for setting them.

Food reformulation

Having elucidated the definition of private partnerships for NCD prevention, it is crucial to emphasize that this research will focus on the collaboration between government agencies and the ultra-processed food and sweetened beverage industries (which may include nonprofit partners and civil society) to tackle the challenges imposed by NCDs centered in food reformulation.¹²⁵²

Food reformulation refers to the modification of the chemical/nutritional composition of food. It differs from product fortification, which represents the addition of micronutrients or other substances.¹²⁵³ In the context of diet-related NCDs, reformulation means altering processed food’s composition to make it healthier.¹²⁵⁴ Hence, reformulation aims to remove trans fatty acids, limit salt/sodium, overconsumption, limit sugar, and reduce the overall energy content or density of a product (measured in calories or kilojoules).¹²⁵⁵ Food reformulation also includes limiting portion and package size to reduce energy intake.¹²⁵⁶

Food reformulation is understood as addressing the nutritional imbalances in contemporary dietary patterns.¹²⁵⁷ In the context of NCD prevention, food reformulation has been recognized

¹²⁵¹ Milton Friedman, ‘The Social Responsibility of Business Is to Increase Its Profits’ in Walther Ch Zimmerli, Markus Holzinger and Klaus Richter (eds), *Corporate Ethics and Corporate Governance* (Springer 1970).

¹²⁵² It must be highlighted that food reformulation might encompass other forms of engagement with the food and sweetened beverage industries. For instance, when front-of-package labelling is on a voluntary basis, one of the approaches to meet the labelling requirements is through product reformulation. In this case, it also comprehends public education and information about a product. Nevertheless, for matters of limitation, this research primarily focuses on analyzing PPPs that include food reformulation as a central component.

¹²⁵³ Garde, *EU Law and Obesity Prevention* (n 710) 237.

¹²⁵⁴ Jenny Claire Kaldor, ‘Food Reformulation for NCD-Prevention: Regulatory Options and Potential Barriers’ (2018) 18 QUT Law Review 95.

¹²⁵⁵ *ibid.*

¹²⁵⁶ World Health Organization, *Reformulation of Food and Beverage Products for Healthier Diets* (WHO 2022).

¹²⁵⁷ Gyorgy Scrinis and Carlos Augusto Monteiro, ‘Ultra-Processed Foods and the Limits of Product Reformulation’ (2017) 21 Public Health Nutrition 247.

as a potential “powerful public health intervention”, as it targets improvements upstream in the food supply, enhancing the nutritional quality of foods without requiring individual consumers to change their behavior.¹²⁵⁸

Furthermore, reformulation has been proven to be a cost-effective strategy for improving dietary habits.¹²⁵⁹ In addition, it is considered an “equitable” approach, as it benefits individuals from lower socioeconomic backgrounds who may struggle to change their health behaviors, even when provided with additional information.¹²⁶⁰

In Europe, food reformulation is one strategy recommended to tackle unhealthy diets. In 2023, the FABLE (Food and Beverages Label Explorer) tool was launched to support this effort.¹²⁶¹ FABLE makes data collected on branded food and drinks publicly available, for researchers, policymakers, industry (including small businesses), and the public.¹²⁶² It identifies that the tool enables transparent monitoring of the EU food supply, helping drive reformulation, inform policy decisions.¹²⁶³

At the national level, many countries have adopted voluntary approaches to food reformulation.¹²⁶⁴ For instance, Germany adopted the National Reduction and Innovation Strategy for Sugar, Fats, and Salt in Processed Foods in 2018, which included target agreements for sugar reduction in soft drinks, fruit beverages with added sugar, breakfast cereals for children, and salt reduction in frozen pizzas and artisanal bread.¹²⁶⁵ In the Netherlands, the salt reduction strategy includes industry engagement to reduce the salt content of foods through reformulation.¹²⁶⁶

¹²⁵⁸ Kaldor, ‘Food Reformulation for NCD-Prevention’ (n 1254).

¹²⁵⁹ Rebolledo and others, ‘Changes in the Critical Nutrient Content of Packaged Foods and Beverages’ (n 844).

¹²⁶⁰ *ibid.*

¹²⁶¹ Petros Maragkoudakis, ‘Reformulating Our Food for a Healthier Life’ (*Knowledge for Policy* 2023) <https://knowledge4policy.ec.europa.eu/blog/reformulating-our-food-healthier-life%E2%80%AF_en> accessed 23 June 2025.

¹²⁶² *ibid.*

¹²⁶³ Joana Dias, Evangelia Grammatikaki and Jan Wollgast, ‘The EU Food and Beverages Labels Explorer (FABLE)—a New Open-Access Web-Based Tool to Monitor Branded Food Products across Europe’ (2023) 91 *Proceedings* 57.

¹²⁶⁴ Yevgeniy Goryakin and others, ‘7 Special Focus: The Health and Economic Impact of Food Reformulation’, *The Heavy Burden of Obesity: the Economics of Prevention* (OECD Health Policy Studies 2019).

¹²⁶⁵ Food Drink Europe, ‘German National Reduction and Innovation Strategy: A Reformulation Success Story’ (*Food Drink Europe* 2023) <<http://www.fooddrinkeurope.eu/industry-action/framework-agreement-on-food-reformulation/>> accessed 19 November 2024. Please note that this website can be biased since FoodDrinkEurope is an industry organization representing the European food and drink sector

¹²⁶⁶ Elisabeth HM Temme and others, ‘Salt Reductions in Some Foods in the Netherlands: Monitoring of Food Composition and Salt Intake’ (2017) 9 *Nutrients* 791.

According to the OECD, in 2016, the most common targets for reformulation realized by the food industry were salt or sodium (67%), sugar (61%), saturated fat (50%), and trans-fat (47%).¹²⁶⁷ In addition, in 2018, companies declared that the majority of food companies had reformulation programs to offer consumers healthier products, and they reported having reformulated 320,000 products since 2015 to support healthier options.¹²⁶⁸

Thus, food reformulation, for being seen as a promising public health strategy that targets industry-level change rather than individual behavior, and also a practice that countries continue to rely on, will serve as the focus of this research on PPPs for NCD prevention.

Scope limitations

As a matter of clarification and emphasis, this research will not focus on partnerships for research purposes. Thus, it excludes partnerships where the public authority is exclusively represented by academia.¹²⁶⁹ Nonetheless, it should be noted that academia may still be a participant in the collaborative effort. As clarified above, the partnerships under consideration must involve one public partner represented by a government authority and one private partner represented by the food/sweetened beverage industry. The inclusion of additional partners in the collaboration does not alter the criteria.

It is imperative to highlight the existence of PPPs for NCD prevention, which focus on the determinant of physical inactivity. For instance, EPODE in France, Let's Move! by Michelle Obama in the US, and AGITA in Brazil, inter alia.¹²⁷⁰ Nevertheless, this research specifically centers on the collaborations that impact "unhealthy diet," which constitutes another major factor contributing to the development of NCDs.

Moreover, initiatives focused on advertising, marketing, and promotion of unhealthy products have been largely adopted in industry initiatives such as self-regulation.¹²⁷¹ There are also examples of PPPs in this area, such as the EU Platform for Action on Diet, Physical Activity

¹²⁶⁷ Goryakin and others, '7 Special Focus' (n 1264).

¹²⁶⁸ Important to note that the source cited by OECD is the Consumer Goods Forum which again is an organization of retailers and manufacturers, including major food companies.

¹²⁶⁹ It is my understanding that partnerships focused on research are problematic because of the influence of the results of research by the private actor, as has been proven with the tobacco industry.

¹²⁷⁰ Gostin, *Global Health Law* (n 3) 398.

Let's move has different focus point. One being "Eat healthy" with practices such as providing healthier foods in schools. And the other one "Get active" to helping kids become more physically active. Let's Move, 'Learn the Facts' (*Let's Move* 2010) <<https://letsmove.obamawhitehouse.archives.gov/learn-facts/epidemic-childhood-obesity>> accessed 4 July 2025.

¹²⁷¹ See Part 2, Chapter 8, III.

and Health.¹²⁷² However, the ultra-processed food and sweetened beverages industries adeptly exploit loopholes to promote their unhealthy products, in particular to children, a practice that has come under intense examination and criticism.¹²⁷³ Consequently, this research will not delve deeper into this subject.¹²⁷⁴

The realm of access to healthy foods (such as vegetables and fruits) presents a distinct landscape, encompassing facets such as public procurement and even trade components of subsidies. While this research acknowledges the significance of facilitating access to healthier foods for the population, it will not explore this particular aspect in further detail.

Thus, this research will focus on voluntary collaborations between governments and food corporations with the common aim of food reformulation (reducing critical nutrient components such as salt, sugar, and fats) for NCD prevention (which indirectly would promote public health).

4 Legal framework

Unlike traditional public-private partnerships and global health PPPs, partnerships for NCD prevention operate within a legal grey zone. There is currently no formal regulatory framework governing these collaborations, leaving significant ambiguity in their structure and enforcement.

The lack of a consistent legal foundation means that NCD-focused PPPs vary widely in their form and the terms under which they are established. In addition, as will be presented in the case studies analyses, non-compliance has no legal consequences.

In traditional PPPs, a breach of contract by the private partner often results in enforceable consequences, such as contract termination or the transfer of assets back to the public authority.¹²⁷⁵ The same is not true for partnerships for NCD prevention. Even when agreements are in place, private partners face little to no repercussions for failing to meet public health

¹²⁷² Part 2, Chapter 6, II, 3.

¹²⁷³ For example: UNICEF, *A Child Rights-Based Approach to Food Marketing: A Guide for Policy Makers* (April 2018); Garde, 'Harmful Commercial Marketing and Children's Rights' (n 691); Marks, *The Perils of Partnership* (n 1188) 62.

¹²⁷⁴ Additionally, thesis focuses on industry-level interventions that alter the composition of food products themselves (upstream interventions in the food supply), PPPs centered on marketing fall outside its scope since they focus on consumer behavior.

¹²⁷⁵ Part 3, Chapter 9, II, 4 Legal framework.

objectives. For example, under the UK Responsibility Deal, the food industry did not achieve its salt reduction targets, and no penalties were imposed.¹²⁷⁶

Finally, from a regulatory perspective, there are different forms of public health regulations.¹²⁷⁷ Relevant to PPPs, there are two. First, quasi-regulation is an approach where the government influences the development and implementation of self-regulation by industry without enacting formal legislation.¹²⁷⁸ For example, governments may encourage self-regulation by threatening to introduce legislation if voluntary measures fail or by citing existing self-regulation as justification for avoiding legislative action. Public-private partnerships for NCD Prevention have been interpreted under this category, such as the UK Responsibility Deal and Australia's Food and Health Dialogue.¹²⁷⁹

The second is co-regulation, which involves a more structured collaboration: government and industry jointly develop, administer, and enforce a regulatory regime. Governments often prescribe self-regulation guidelines while delegating specific regulatory responsibilities to the industry itself.¹²⁸⁰

While quasi-regulation appears to be the intended approach for many NCD prevention PPPs, in practice, they often resemble a form of co-regulation, as the government ended up delegating public responsibilities to the industry. Here, industry and government jointly develop a (non)regulatory regime towards the food industry.

II Case studies: public-private partnerships with ultra-processed food and the sweetened beverage industries

1 Sample Selection

Public-private partnerships for the prevention of NCDs represent an evolving field. Examining selected case studies allows for a deeper understanding of these collaborations and their specific

¹²⁷⁶ Only in 2018 the UK adopted a Soft Drinks Industry Levy. Levy HM Revenue & Customs, 'Guidance for the Soft Drinks Industry Levy. Including How to Check If Your Drink Is Liable, as Well as How to Register, Submit Returns and Pay Your Bill' (*Gov UK* 2024) <<https://www.gov.uk/government/collections/soft-drinks-industry-levy-detailed-information>> accessed 8 July 2025.

¹²⁷⁷ Part 1, Chapter 3, II, 2 Regulatory approaches.

¹²⁷⁸ Heenan and others, 'Legal and Regulatory Instruments for NCD Prevention' (n 365).

¹²⁷⁹ *ibid.*

¹²⁸⁰ *ibid.*

characteristics. As it is not feasible to identify or analyze all existing PPPs, this thesis focuses on representative examples that illustrate the diverse forms, outcomes, and legal aspects of such PPPs, with a particular focus on voluntary agreements aimed at product reformulation.¹²⁸¹

The case selection is based on a comprehensive literature review of PPPs in the NCD context, with a particular emphasis on reformulation strategies. The first case analyzed is the Responsibility Deal in the United Kingdom, being the most famous case of PPP in the context of public health promotion. The RD has been adopted with the idea of a strategic alternative to legislative measures and enhance governance efficacy and efficiency. Its structural similarity to traditional PPPs makes it a valuable case for in-depth analysis. Moreover, its eventual failure and discontinuation render it particularly relevant for examining the legal and institutional limitations of such partnerships.

The second case lies at the opposite end of the spectrum, representing a successful and ongoing initiative: the Danish Whole Grain Partnership. This PPP has been cited as a model for replication in other countries due to its sustained implementation and measurable public health outcomes. It highlights the institutional conditions that may contribute to the relative success of PPPs.

The other examples do not explicitly identify themselves as PPPs. However, this analysis will demonstrate how they can align with the definition of PPPs for NCD prevention. This section will turn to specific dietary component reformulation. First, the Declaration of Milan in Switzerland, which focuses on sugar reduction through voluntary commitments. This model represents a formalized attempt of PPPs for NCD prevention, though its gaps and loopholes deserve a detailed legal analysis. Second, the US Voluntary Sodium Reduction Goals, aimed at lowering sodium content in packaged foods, similarly contain significant loopholes.

Each case study is analyzed in three parts: First, the background and form of the agreement are presented to clarify the context and nature of the PPP. Second, the analysis and results draw on a combination of findings from the existing literature and original legal analysis, highlighting how each example aligns with the structural elements of the PPP definition adopted in this thesis. This step also identifies legal gaps, particularly regarding accountability, transparency,

¹²⁸¹ This thesis acknowledges the existence of other relevant examples of public-private partnerships in the prevention of non-communicable diseases, such as the Healthy Food Partnership in Australia. However, due to the scope and limitations of this research, the selected examples focus on those from Europe and the United States. These case studies were chosen based on their accessibility, availability of data, and relevance to the research objectives. The exclusion of other initiatives does not diminish their importance but rather reflects the need for a more focused and manageable analysis within the constraints of this work.

and enforcement. Finally, the section offers a brief conclusion highlighting what ultimately happened to the PPP and underscoring the key elements that contributed to its success or failure, such as design, monitoring mechanisms, and the balance of public and private interests.

2 Public Health Responsibility Deal

2.1 Background and form of agreement

A major example of a public-private partnership is the Public Health Responsibility Deal (RD), which was launched in England in March 2011 by the Conservative-Liberal Democrat coalition.¹²⁸² Positioned as a strategic alternative to legislative measures, the RD sought to enhance governance efficacy and efficiency.¹²⁸³ The RD aimed to bring together public sector, academic, commercial, and voluntary organizations in five networks (food, alcohol, physical activity, health at work, and behavior change) to achieve public health goals.¹²⁸⁴ Andrew Lansley, the former Secretary of State for Health, defended the RD, arguing that “by working in partnership, public health, commercial and voluntary organizations can agree practical actions to secure more progress, more quickly, with less cost than legislation”.¹²⁸⁵ According to the official document from the RD, the former Secretary of State for Health signed the RD and many companies. However, there is no information on who the person was signing on behalf of the industry.¹²⁸⁶

The Public Health Responsibility Deal delineated key strategies for governmental intervention to enhance public health. These strategies encompassed promoting healthier behaviors and lifestyles, adapting the environment to make healthy choices easier, and strengthening self-esteem, confidence, and personal responsibility.¹²⁸⁷ The RD was structured into three major parts: core commitments, collective and individual pledges, and supporting pledges.

The five core commitments set the scope and purpose of the Responsibility Deal. Partners in the RD were required to endorse these commitments, which included recognizing the

¹²⁸² Rob Ralston, ‘The Informal Governance of Public-Private Partnerships in UK Obesity Policy: Collaborating on Calorie Reduction or Reducing Effectiveness?’ (2021) 289 *Social Science & Medicine* 114451.

¹²⁸³ *ibid.*

¹²⁸⁴ Mark Petticrew and others, ‘The Public Health Responsibility Deal: How Should Such a Complex Public Health Policy Be Evaluated?’ (2013) 35 *Journal of Public Health* 495.

¹²⁸⁵ UK Department of Health, *The Public Health Responsibility Deal* (March 2011).

¹²⁸⁶ *ibid.*

¹²⁸⁷ *ibid.*

participants’ “vital” role in improving people’s health, encouraging and enabling people to adopt a healthier diet, providing a culture of responsible drinking, encouraging people to become more physically active, and supporting the workforce in leading healthier lives. The RD incorporated collective and individual pledges to operationalize these core commitments.¹²⁸⁸

Collective pledges represented collaborative initiatives agreed upon by sector members to advance specific core commitments. According to the launch plan, all partners had signed up to deliver at least one of the collective pledges. In contrast, the individual pledges were specific to a particular organization or sub-group within a sector.

There were also five supporting pledges defining the operating principles of the RD. First, to support the Public Health Responsibility Deal approach and encourage other organizations to sign up. Secondly, the recognition of the significance of collaborative efforts among diverse entities across sectors to enhance public health outcomes. Third, the commitment to contribute to the monitoring and evaluation of progress against the pledges. Fourth, it affirmed its dedication to disseminating messages aligned with official governmental public health directives. Lastly, it underscored its aspiration to enhance the effectiveness of the Public Health Responsibility Deal by creating additional pledges to support the five core commitments.¹²⁸⁹

The collective pledges covered alcohol, food, physical activity, and health at work. These corresponded to the four “networks” of the RD. Upon endorsing a specific pledge, participating organizations were required to devise a comprehensive delivery plan, delineating the precise steps they intended to undertake to actualize their commitment. Additionally, partners committed to actively monitoring their progress against predetermined benchmarks and furnishing annual progress reports.¹²⁹⁰

Originally, the food pledges focused on out-of-home calorie labelling, salt reduction, artificial trans fats removal (non-use of artificial trans fats and artificial trans fats removal), calorie reduction, salt catering, fruit, and vegetables. Subsequently, additional pledges were incorporated, addressing areas such as front-of-pack nutrition labelling and saturated fat reduction.¹²⁹¹

¹²⁸⁸ *ibid.*

¹²⁸⁹ *ibid.*

¹²⁹⁰ Knai and others, ‘The Public Health Responsibility Deal’ (n 32).

¹²⁹¹ As this research is focused on unhealthy diets it will only focus in the food pledges and network. Department of Health, ‘Public Health Responsibility Deal: Food Pledges’ (*National Archives* 2011)

The out-of-home pledge calorie labelling aimed to provide information for people to make healthier choices when eating out, and to encourage out-of-home food businesses to make healthier options more available. It included interventions such as information on calories at point of choice (menu boards in quick service restaurants and/or on menus or shelf edging in other types of business, or other points that are equally effective), information on calories per portion/item/meal.¹²⁹²

The salt reduction pledge aimed to achieve the public health goal of consuming no more than 6g of salt per person per day through reformulation, provision of information to customers to help them make healthier choices to reduce salt, and shifts in cooking practices and menu planning of food service to reduce salt in the food.

The artificial trans fats removal pledge had two parts. First, the non-use of artificial trans fats affirms that “we do not use ingredients that contain artificial trans fats”.¹²⁹³ And the second pledge: Artificial Trans Fat Removal: “we are working to remove artificial trans fats from our products within the next 12 months”.¹²⁹⁴

The fruit and vegetables pledge had the idea to promote a positive environment that supports and enables people to increase their consumption of fruit and vegetables by making fruit and or vegetables (including frozen, canned, dried) more affordable, for example through promotions or value ranges, improving availability of fruit and or vegetables through promotions, for example, meal deals in workplace restaurants, food manufacturers/suppliers can reformulate composite products to increase fruit and vegetable content.¹²⁹⁵

<<https://webarchive.nationalarchives.gov.uk/ukgwa/20180201175712/https://responsibilitydeal.dh.gov.uk/food-pledges/>> accessed 4 July 2025.

¹²⁹² Cécile Knai and others, ‘Has a Public–Private Partnership Resulted in Action on Healthier Diets in England? An Analysis of the Public Health Responsibility Deal Food Pledges’ (2015) 54 *Food Policy* 1.

¹²⁹³ Department of Health, ‘F3. Artificial Trans Fats Removal’ (*National Archives* 2012) <<https://webarchive.nationalarchives.gov.uk/ukgwa/20130104170741/http://responsibilitydeal.dh.gov.uk/f3a-non-use-of-artificial-trans-fats/>> accessed 4 July 2025.

¹²⁹⁴ *ibid.*

¹²⁹⁵ Department of Health, ‘F6. Fruit and Vegetables’ (*National Archives* 2012) <<https://webarchive.nationalarchives.gov.uk/ukgwa/20130104155800/http://responsibilitydeal.dh.gov.uk/2012/1/15/f6-factsheet/>> accessed 4 July 2025.

The calorie reduction pledge also included reformulating recipes and menus, encompassing the development of lower-calorie options.¹²⁹⁶ The front-of-pack nutrition labelling concerned the implementation of this public health tool, in accordance with the UK 2013 scheme.¹²⁹⁷

The saturated fat focused on reformulation efforts to achieve absolute reductions in saturated fat levels, substitution of saturated fats by unsaturated fats through dietary advice to consumers, consumer awareness campaigns, product/menu reformulation, and reviewing portion sizes.¹²⁹⁸

These pledges have been designed and developed by the networks and approved by the relevant network chairs and the Department of Health.¹²⁹⁹ Initially, the Food Network included stakeholders from diverse sectors, including catering, retail, and manufacturing, alongside representation from NGOs, public health specialists, and local government bodies.¹³⁰⁰ However, the withdrawal of numerous non-governmental organizations led to a notable shift in the composition of the food network, predominantly consisting of representatives from the food industry.¹³⁰¹ For instance, by 2013, following two years of RD implementation, the Faculty of Public Health withdrew from the food network, citing concerns over the prioritization of private interests and the perceived lack of evidence supporting that the Responsibility Deal was achieving its goal of being faster and more effective than legislation.¹³⁰²

2.2 Analysis and results

The RD is the most well-established example of PPP for NCD prevention. It is noteworthy to draw a parallel with the UK's earlier role in promoting the establishment of PPPs more broadly, inspired by the principles of New Public Management.¹³⁰³ In this context, the RD represents a

¹²⁹⁶ Department of Health, 'F4. Calorie Reduction' (*National Archives* 2012) <<https://webarchive.nationalarchives.gov.uk/ukgwa/20130104162226/http://responsibilitydeal.dh.gov.uk/2012/03/26/f4-factsheet/>> accessed 4 July 2025.

¹²⁹⁷ Maeve A Kerr, Mary T McCann and M Barbara E Livingstone, 'Food and the Consumer: Could Labelling Be the Answer?' (2015) 74 *Proceedings of the Nutrition Society* 158.

¹²⁹⁸ Department of Health, 'F8. Saturated Fat Reduction' (*National Archives* 2012) <<https://webarchive.nationalarchives.gov.uk/ukgwa/20180201180858/https://responsibilitydeal.dh.gov.uk/pledges/pledge/?pl=41>> accessed 4 July 2025.

¹²⁹⁹ UK Department of Health, *Public Health Responsibility Deal* (n 4).

¹³⁰⁰ *ibid.*

¹³⁰¹ Graham MacGregor, FengJ He and Sonia Pombo-Rodrigues, 'Food and the Responsibility Deal: How the Salt Reduction Strategy Was Derailed' (2015) 350 *BMJ*.

¹³⁰² Clare Panjwani and Martin Caraher, 'The Public Health Responsibility Deal: Brokering a Deal for Public Health, but on Whose Terms?' (2014) 114 *Health Policy* 163.

¹³⁰³ Heather Whiteside, 'Public-Private Partnerships: Market Development through Management Reform' (2019) 27 *Review of International Political Economy* 23.

continuation of this approach, with the UK also leading efforts to promote the idea that the private sector can play a meaningful role in improving public health outcomes.

Under the definition of PPPs for NCD prevention, the RD meets the criteria of a voluntary collaboration between public authorities, most notably the former Secretary of State for Health, and private sector actors, particularly food corporations. This partnership was established to address the growing burden of NCDs, united under the common objective of promoting public health. Among its key initiatives were pledges focused on food reformulation. Shared decision-making is present here since the businesses were defining the pledges together with the public sector.

A research analysis of the RD showed that most (95%) organizations signing up for the food pledges were from the private food sector, including retailers, manufacturers, caterers, and food outlets (such as restaurant chains).¹³⁰⁴ For some pledges, such as the calorie reduction, front-of-pack labelling, and saturated fat pledges, 100% of organizations were from the food sector.¹³⁰⁵ This underlines that decision-making within the partnership, which was intended to be participatory and inclusive, ultimately has revealed a bias toward perspectives from the commercial sector.¹³⁰⁶

According to the official document of the RD, partners agreed to fulfil the monitoring and evaluation requirements for each pledge to which they have signed up which would include publishing progress reports using agreed indicators through their existing annual reporting mechanisms, submit annual updates on the implementation of their pledges to the Department of Health and, where previously agreed within the network, provide supplementary data to support independent assessment or evaluation.¹³⁰⁷ However, it has been highlighted that monitoring was vague.¹³⁰⁸ Reporting requirements were inconsistently applied and, where fulfilled, rarely included verifiable data. Only a minority of participating entities provided concrete information on the evolution of lower-calorie product offerings or reformulation efforts, and even in these cases, it was not possible to establish a causal link between observed changes and participation in the RD.¹³⁰⁹

¹³⁰⁴ The other 5% was represented by education, voluntary and health sectors. Knai and others, 'Has a Public-Private Partnership Resulted in Action' (n 1292).

¹³⁰⁵ *ibid.*

¹³⁰⁶ Ralston, 'The Informal Governance of Public-Private Partnerships in UK Obesity Policy' (n 1282).

¹³⁰⁷ UK Department of Health, *Public Health Responsibility Deal* (n 4).

¹³⁰⁸ Knai and others, 'Has a Public-Private Partnership Resulted in Action' (n 1292).

¹³⁰⁹ *ibid.*

In addition, one of the main critiques has been the vagueness of the food pledges. For instance, within the calorie reduction pledge, most commitments were broadly defined.¹³¹⁰ Another problem pointed out is the lack of a specific focus on reducing sugar intake, despite sugar being recognized as a primary contributor to obesity and non-communicable diseases.¹³¹¹ Detailed analyses of the food pledges have emphasized this deficiency, noting a lack of concerted efforts to address sugar intake, despite claims by RD partners of significant reductions.¹³¹² Furthermore, there is a notable absence of initiatives targeting the marketing of unhealthy foods, such as particularly packaged or processed foods that are high in fat, sugar, and/or sodium.¹³¹³ Finally, pricing policies are only presented under the fruit and vegetable pledge, but no pricing policies have been applied to increase the price of fast food and sugar-sweetened beverages.¹³¹⁴

Studies concluded that the artificial trans fats removal pledge has limited added value.¹³¹⁵ The first part, which had high adherence (90 signatories), was a mere statement confirming the non-use of trans fats and was signed largely by organizations that had already removed trans fats before joining the RD.¹³¹⁶ On the other hand, the second part (concerning removing trans fats from products) has only 11 signatories, which were catering companies and two universities, thus not in a position to reformulate food products at the point of manufacture.¹³¹⁷ Nonetheless, a policy brief published on 10 June 2022 by WHO exemplifies the RD as a successful voluntary approach to reduce the content of trans fats in the food supply.¹³¹⁸ It states that “through the combined efforts of the food industry, industrially produced trans fats has largely been removed from food products without the need for a legal ban on industrially produced trans fats.”¹³¹⁹

Moreover, studies have indicated a significant slowdown in population-level salt intake reductions in England after the implementation of the Public Health Responsibility Deal in 2011.¹³²⁰ This same study highlighted that this “slowdown in population-level salt intake” could be associated with approximately 10,000 additional cases of cardiovascular disease and 1500

¹³¹⁰ Ralston, ‘The Informal Governance of Public-Private Partnerships in UK Obesity Policy’ (n 1282).

¹³¹¹ Knai and others, ‘Has a Public–Private Partnership Resulted in Action’ (n 1292).

¹³¹² *ibid.*

¹³¹³ *ibid.*

¹³¹⁴ *ibid.*

¹³¹⁵ Cécile Knai and others, ‘An Evaluation of a Public-Private Partnership to Reduce Artificial Trans Fatty Acids in England, 2011-16’ (2017) 27 *European Journal of Public Health* 605.

¹³¹⁶ *ibid.*

¹³¹⁷ *ibid.*

¹³¹⁸ WHO, *Reformulation of Food and Beverage Products for Healthier Diets* (n 1256).

¹³¹⁹ *ibid.*, 13.

¹³²⁰ Anthony A Laverty and others, ‘Quantifying the Impact of the Public Health Responsibility Deal on Salt Intake, Cardiovascular Disease and Gastric Cancer Burdens: Interrupted Time Series and Microsimulation Study’ (2019) 73 *Journal of Epidemiology and Community Health* 881; Feng J He and others, ‘Reducing Population Salt Intake—an Update on Latest Evidence and Global Action’ (2019) 21 *The Journal of Clinical Hypertension* 1596.

cases of gastric cancer incidence in the period of 2011–2018.¹³²¹ Notably, the health consequences of this phenomenon were more pronounced among socioeconomically disadvantaged populations, potentially exacerbating disparities and leading to associated healthcare and productivity costs surpassing £1 billion.¹³²²

Finally, one measure to evaluate the effectiveness of the RD has been the idea of assessing “additionality”, which means that a planned or completed activity was a result of the RD, as opposed to an activity that would have happened anyway or that appeared to be already happening irrespective of the RD.¹³²³ It was found that most of the interventions were already in place before the establishment of the RD.¹³²⁴

2.3 Conclusion

Following the 2015 UK general election, the Public Health Responsibility Deal was dissolved.¹³²⁵ One of the main criticisms has been that the RD was closely aligned with industry preferences. This criticism underscores the failure to recognize the inherent conflicts of interest that arise when corporations participate in endeavors and enact policies directed at mitigating the harmful behaviors upon which their profitability centers.¹³²⁶

The pledges were very broad and did not specify how the commitment would be achieved. In addition, it is possible to conclude that most of the proposed interventions favored information provision, awareness raising, and communication with consumers, following the idea of focusing on consumer empowerment and personal responsibility.

Another issue has been that major companies such as Unilever, McDonald’s, and Kellogg’s have failed to commit to the RD.¹³²⁷ For instance, McDonald’s and KFC, though partners of the RD, had not committed to the salt reduction or the calorie reduction pledge.

One more major problem of the RD has been that progress reports were mostly unavailable or very incomplete. The lack of robust and independent target setting, adequate monitoring, and

¹³²¹ *ibid.*

¹³²² *ibid.*

¹³²³ Knai and others, ‘Has a Public–Private Partnership Resulted in Action’ (n 1292).

¹³²⁴ *ibid.*

¹³²⁵ Action on Salt, ‘Department of Health 2010 - 2015’ (*Action on Salt 2015*) <<https://www.actiononsalt.org.uk/reformulation/who-is-responsible-for-salt-reduction-in-the-uk/departments-of-health-2010---2015/>> accessed 12 July 2024.

¹³²⁶ Anna B Gilmore, Emily Savell and Jeff Collin, ‘Public Health, Corporations and the New Responsibility Deal: Promoting Partnerships with Vectors of Disease?’ (2011) 33 *Journal of Public Health* 2.

¹³²⁷ MacGregor, He and Pombo-Rodrigues, ‘Food and the Responsibility Deal’ (n 1301).

enforcement underlines the importance of establishing well-defined targets and setting out clear incentives and sanctions for not demonstrating progress against the targets.¹³²⁸ This emphasizes the importance of the terms of engagement with corporate actors, highlighting the crucial role of transparency in public-private partnerships. In addition, the importance of authority oversight which lacked in this case.

3 The Danish Whole Grain Partnership

3.1 Background and form of agreement

The Danish Whole Grain Partnership is a collaboration between the Danish Veterinary and Food Administration, the Danish Cancer Society, the Danish Heart Foundation, and the Danish Diabetes Association, as well as several food companies, retail chains, and industry associations. It aims to increase the availability of whole grain products (by reformulating existing products to raise their whole grain content) and spread awareness of their beneficial effects.¹³²⁹

The partnership implemented a standardized whole-grain logo, designed and promoted as a tool to convey nutritional guidance from Danish authorities.¹³³⁰ This initiative aims to assist consumers in identifying whole-grain products.

Food manufacturers are allowed to display the whole-grain logo on their products if they meet specific criteria regarding the whole-grain content within designated product categories.¹³³¹ For instance, breakfast cereals and muesli must contain at least 65% whole grain, rice must be 100%, and concerning pasta and noodles, at least 60% whole grain.¹³³² Additionally, it is essential to note that products must also comply with the nutrient profile requirements set by the Nordic Keyhole nutrition label, a front-of-package labelling system adopted in the country. This stipulation prevents the logo from being used on unhealthy products, such as high-fat or high-sugar biscuits and cakes.¹³³³

¹³²⁸ Knai and others, 'Has a Public-Private Partnership Resulted in Action' (n 1292).

¹³²⁹ The Danish Whole Grain Partnership, 'About Us' (*Fuldkorn* 2019) <<https://fuldkorn.dk/en/about-us/>> accessed 28 July 2024.

¹³³⁰ Neil Bernard Boyle and others, 'Increasing Fibre Intake in the UK: Lessons from the Danish Whole Grain Partnership' (2023) 131 *British Journal of Nutrition* 35.

¹³³¹ *ibid.*

¹³³² OECD, *Healthy Eating and Active Lifestyles: Best Practices in Public Health* (OECD Publishing 2022) 237.

¹³³³ Boyle and others, 'Increasing Fibre Intake in the UK' (n 1330).

The partnership is structured with a formal framework, comprising a board of representatives from each partner category: government, health NGOs, and industry. The board includes seven representatives from three major partner categories: the Danish Veterinary and Food Administration, health NGOs, and the food industry. There is one board chair and two vice chairs representing each partner category.¹³³⁴ From the companies, most of the board members are CEO's, including a few directors, and from the public sector, it includes the Head of Unit of the Danish Veterinary and Food Administration.¹³³⁵

The board is responsible for making decisions regarding strategy, action plans, budgets, and partnership financing. All partners are accountable for the execution of activities, and they finance all these activities independently.¹³³⁶ Finally, to become a member of the partnership, manufacturers pay a membership fee that varies depending on their size.¹³³⁷

The partnership is characterized by each partner contributing distinctly and having complementary roles to the partnership. As an illustration, the development of the logo and the criteria for its use were a collaborative effort among the partners.¹³³⁸ Public authorities are responsible for enforcing the use of the logo, issuing dietary guidelines, educating the public on the health benefits of whole grains, and developing guidelines for relevant professionals. On their part, industry partners, including millers, craft bakeries, and food manufacturers, are tasked with increasing the availability of whole-grain products that meet the logo's criteria and reformulating existing products to enhance their whole-grain content. The retail sector supports these efforts by promoting whole-grain products through in-store activities and special promotions. Finally, NGOs play a crucial role in communicating the health benefits of whole grains and contributing to the body of evidence supporting these benefits.¹³³⁹

Concerning risk-sharing, the partnership established a code of conduct to guide risk-sharing, with all partners agreeing to adhere to its principles.¹³⁴⁰ At its creation, a corporate agreement and a partnership agreement were instituted. Partners commit to a range of obligations over a

¹³³⁴ Sofia Lourenço and others, 'The Whole Grain Partnership—How a Public–Private Partnership Helped Increase Whole Grain Intake in Denmark' [2019] *Cereal Foods World*.

¹³³⁵ The Danish Whole Grain Partnership, 'About Us' (n 1335).

¹³³⁶ Boyle and others, 'Increasing Fibre Intake in the UK' (n 1330).

¹³³⁷ OECD, *Healthy Eating and Active Lifestyles* (n 1332).

¹³³⁸ Boyle and others, 'Increasing Fibre Intake in the UK' (n 1330); Carsten Greve and Rikke Iben Neess, 'The Evolution of the Whole Grain Partnership in Denmark' (CBS 2014).

¹³³⁹ Boyle and others, 'Increasing Fibre Intake in the UK' (n 1330).

¹³⁴⁰ Greve and Iben Neess, 'The Evolution of the Whole Grain Partnership in Denmark' (n 1338) 20.

three-year partnership period, with an annual option to withdraw. One year before the end of a partnership period, partners decide whether to continue their involvement.¹³⁴¹

3.2 Analysis and results

Under the definition of PPPs for NCD prevention, the Danish Whole Grain Partnership meets the criteria of a voluntary collaboration between public authorities, the Danish Veterinary and Food Administration (government), and private sector actors, represented by the food industry (millers, craft bakeries, and food manufacturers). The partnership was established to address the issue of insufficient whole grain consumption as a way to improve population health.¹³⁴² Food industry partners contribute by increasing the availability of products that meet the partnership's logo criteria and by reformulating existing products to raise their whole grain content. The element of shared decision-making is present through a governing board composed of public and private sector representatives.

Since the adoption of the partnership in 2008, empirical studies have shown that the consumption of whole grains has increased for children and adults.¹³⁴³ According to a report issued by the partnership, there has been a notable increase in the consumption of whole grain products among the Danish population.¹³⁴⁴ According to the Partnership, the intake of Danes in whole grain increased from 36 to 63 g/10 MJ/day.¹³⁴⁵ Moreover, studies found that in 2011-2012, 27% of the population met the recommended 75g threshold, and in 2020, 54% met the recommended whole grain consumption threshold.¹³⁴⁶ It has been highlighted that in 2019, the Danish population was eating 82g of whole grains, the highest intake in Europe.¹³⁴⁷

The Whole Grain Partnership has been described as a “world-renowned intervention” for boosting whole grain consumption.¹³⁴⁸ Key characteristics were highlighted for its success. First, more whole-grain products are available. In addition, awareness of the Whole Grain logo has risen significantly.¹³⁴⁹

¹³⁴¹ *ibid.*

¹³⁴² Qiao and others, ‘Global Burden of Non-Communicable Diseases’ (n 52).

¹³⁴³ OECD, *Healthy Eating and Active Lifestyles* (n 1332).

¹³⁴⁴ Greve and Iben Næss, ‘The Evolution of the Whole Grain Partnership in Denmark’ (n 1338) 22.

¹³⁴⁵ *ibid.*

¹³⁴⁶ OECD, *Healthy Eating and Active Lifestyles* (n 1332).

¹³⁴⁷ Rachel Dixon, ‘The Wholegrain Revolution! How Denmark Changed the Diet – and Health – of Their Entire Nation’ (*The Guardian* 2025) <<http://www.theguardian.com/lifeandstyle/2025/apr/23/the-wholegrain-revolution-how-denmark-changed-the-diet-and-health-of-their-entire-nation>> accessed 5 May 2025.

¹³⁴⁸ OECD, *Healthy Eating and Active Lifestyles* (n 1332).

¹³⁴⁹ Greve and Iben Næss, ‘The Evolution of the Whole Grain Partnership in Denmark’ (n 1338) 20.

Another important characteristic of this PPP is the reformulation of whole-grain products. As a result of the reformulation and the development of new whole-grain products, studies have shown that the number of products carrying the whole-grain logo has increased from 150 registered products in 2009 to approximately 800 in 2018.¹³⁵⁰

The success of the Danish Whole Grain Partnership led to the European project “European Action on Whole Grain Partnerships,” which was implemented from 2019 to 2022 to assist Romania, Slovenia, and Bosnia and Herzegovina in transferring and adapting the Whole Grain Partnership to their local settings.¹³⁵¹ Still, in 2025, the Danish Whole Grain Partnership is seen as a success case.¹³⁵²

3.3 Conclusion

In conclusion, a critical factor in the success of the whole grain partnership has been the alignment of industry interest with public health goals. In this case, the industry’s motivation to reformulate products to include more whole grains was driven not only by health considerations but also by the potential for increased profitability. This mutually beneficial outcome facilitated smoother collaboration between public and private actors.¹³⁵³

However, this dynamic becomes more challenging when it comes to reformulation efforts involving salt or sugar reduction. In such instances, industries frequently raise concerns that these changes may compromise the taste of their products, ultimately impacting consumer satisfaction and sales. This highlights the tension between public health objectives and market-driven priorities.

4 The Declaration of Milan

4.1 Background and form of agreement

In Switzerland, sugar reduction has been tackled through a voluntary approach. In 2015, the Swiss federal authorities and ten food companies signed the Declaration of Milan, a voluntary

¹³⁵⁰ Lourenço and others, ‘The Whole Grain Partnership’ (n 1334).

¹³⁵¹ The European Public Health Association, ‘JA WholeGrain: A European Action on Whole Grain Partnerships’ (*EUPHA* 2023) <<https://eupha.org/JA-WholeGrain>> accessed 18 February 2025.

¹³⁵² Dixon, ‘The Wholegrain Revolution!’ (n 1347).

¹³⁵³ Interview with Susanne Tøttenborg, a senior consultant with the Danish Cancer Society, involved in the Danish Whole Grain Partnership and the Six a Day Partnership on 12 September 2024.

agreement to reduce the sugar content of yogurts and breakfast cereals.¹³⁵⁴ It can be considered a negotiation solution in which the form of agreement was done through a Memorandum of Understanding.

Analyzing closely who signed the document, it is essential to highlight that from the government, the document was signed by Alain Berset, the former Swiss Federal Council, and from the industries, it varied. For instance, from Bio-familia AG it was the marketing manager, from Bossy Céréales SA it was the CEO, from Coop Cooperative it was the chairman of the executive board, from Cremo SA the director, from Emmi Gruppe the head of Switzerland, from Migros the head of sustainability & RM Directorate, from Molkerei Lanz AG it was the managing director and owner, from Nestlé it was the CEO, from Schweizerische Schälmmühle E. Zwicky AG it was the managing director, and from WanderAG the CEO.¹³⁵⁵

In 2017, other major companies such as Aldi Suisse SA, Danone Suisse SA, Kellogg (Schweiz) GmbH, and Lidl Schweiz AG joined the round table. Again, different representatives signed the document. From Aldi, it was the regional manager, from Danone, the senior manager of public affairs, from Kellogg, the managing director, and from Lidl, the CEO.¹³⁵⁶ For the first time, the signatories set concrete values to be achieved. By the end of 2018, companies should have reduced the amount of added sugar in yoghurts by a further 2.5% and 5% for breakfast cereals.¹³⁵⁷

In February 2023, ten new companies (Mineralquellen Adelboden AG, Coca-Cola HBC Suisse SA, Goba AG, Eaux Minérales d'Eptingen SA, RAMSEIER Suisse SA, Mineralquellen Rhäzüns, Rivella SA, Trivarga AG, Vivi Kola AG, Volg Konsumwaren AG) joined the Declaration of Milan being signed by their managing directors, CEO's or country managers.¹³⁵⁸

¹³⁵⁴ Office Fédéral de la Sécurité Alimentaire et des Affaires Vétérinaires, *La Confédération et les principales entreprises suisses s'engagent à réduire les sucres dans certaines denrées alimentaires*, 4 août 2015 <<https://www.blv.admin.ch/blv/fr/home/dokumentation/nsb-news-list.msg-id-58236.html>> accessed 22 April 2024.

¹³⁵⁵ *Memorandum of Understanding über die Zusammenarbeit im Rahmen der Zuckerreduktion in Joghurts und Frühstückscerealien* zwischen dem Eidgenössischen Departement des Innern (EDI) und bio-familia AG, Bossy Céréales SA, Coop Genossenschaft, Cremo SA, Emmi Gruppe, Migros-Genossenschafts-Bund, Molkerei Lanz AG, Nestlé Suisse SA, Schweizerische Schälmmühle E. Zwicky AG, Wander AG.

¹³⁵⁶ *Ergänzung zum Memorandum of Understanding über die Zusammenarbeit im Rahmen der Zuckerreduktion in Joghurts und Frühstückscerealien* (4 August 2015) zwischen dem Eidgenössischen Departement des Innern (EDI) und Aldi Suisse AG, Danone AG, Kellogg (Schweiz) GmbH, Lidl Schweiz.

¹³⁵⁷ Office Fédéral de la Sécurité Alimentaire et des Affaires Vétérinaires, *La Confédération et les entreprises élargissent la Déclaration de Milan sur la réduction des sucres*, 5 septembre 2017 <<https://www.blv.admin.ch/blv/fr/home/dokumentation/nsb-news-list.msg-id-67988.html>> accessed 22 April 2024.

¹³⁵⁸ *Erklärung von Mailand 2019–2024, Anhang zur Zuckerreduktion in Erfrischungsgetränken* (14 February 2023), zwischen dem Eidgenössischen Departement des Innern (EDI) und Aldi Suisse AG, Coca-Cola Schweiz GmbH, Coop Genossenschaft, Cremo SA, Danone AG, Goba AG, Migros-Genossenschafts-Bund, Mineralquelle

The companies have voluntarily pledged to reduce the sugar content in yoghurts and breakfast cereals by the end of 2024. On this occasion, new product categories were included: soft drinks, dairy drinks, and quark.¹³⁵⁹ The companies had agreed to reduce the sugar content of their products by 10% until the end of 2024.¹³⁶⁰

4.2 Analysis and results

The Declaration of Milan can be considered a form of PPP for NCD prevention, as it represents a voluntary collaboration between the Swiss government and various food industry actors aimed at reducing sugar content through product reformulation that would promote healthier dietary habits. In this partnership, public authorities and private companies jointly committed to a shared goal: lowering sugar levels in food products. The reformulation targets were developed collaboratively, reflecting a clear element of shared decision-making between the public and private sectors.

As part of the Declaration of Milan, the FSVO has developed a Guide for the definition and calculation of added sugars, intended to ensure that all companies participating in the survey use the concept of “added sugars” in the same way and calculate the added sugar content of their products comparably.¹³⁶¹

The FSVO adopts the European definition found in Annex II of the EU Framework for National Initiatives on Selected Nutrients: “The term added sugars refers to sucrose, fructose, starch hydrolysates (glucose syrup, high-fructose syrup) and other isolated sugar preparations used as such or added during the preparation or manufacture of the food. Sugar alcohols (polyols), such as sorbitol, xylitol, mannitol, and lactitol, are generally not included under the term added sugars. For the purposes of this annex, the term added sugars also includes sugars present in honey, syrups and fruit juices as well as fruit juice concentrates.”¹³⁶²

Eptingen AG, Mineralquelle Rhäzüns, Mineralquellen Adelboden AG, Nestlé Suisse AG, RAMSEIER Suisse AG, Rivella Group, Trivarga AG, Vivi Kola AG, Volg Konsumwaren AG.

¹³⁵⁹ Office Fédéral de la Sécurité Alimentaire et des Affaires Vétérinaires, ‘*Élargissement significatif de la Déclaration de Milan*’, 14 février 2023 <<https://www.blv.admin.ch/blv/en/home/dokumentation/nsb-news-list.msg-id-93058.html>> accessed 22 April 2024.

¹³⁶⁰ *ibid.*

¹³⁶¹ Office Fédéral de la Sécurité Alimentaire et des Affaires Vétérinaires, *Guide de l’OSAV pour la définition et le calcul des sucres ajoutés* (2018) <www.blv.admin.ch/blv/fr/home/lebensmittel-undernaehrung/ernaehrung/produktzusammensetzung/zuckerreduktion.html> 22 April 2024.

¹³⁶² *ibid.*

The FSVO also considers as added sugars those types of sugars derived from other foods that have a sweetening effect, such as fruit powders and pulps or malt extracts, in order to ensure that this definition aligns with the new food legislation and, more specifically, with the nutrition claim “no added sugars”.¹³⁶³

According to a survey conducted by the FSVO, companies have achieved the targets set in 2017: between 2016 and 2018, they reduced added sugars by 3.5% in yogurts and 13% in breakfast cereals.¹³⁶⁴ Although reduction targets have been achieved, sugar levels in yoghurts and breakfast cereals yoghurts and breakfast cereals are still considerably high.¹³⁶⁵ On this occasion, they decided to go further, aiming for another 10% less in yoghurts and 15% less in cereals by 2024.¹³⁶⁶

A few critical points can be highlighted from the Declaration of Milan. It is accorded that companies can terminate the collaboration at any time without providing reasons by only submitting a written notice to the General Secretariat.¹³⁶⁷ Moreover, it states that the General Secretariat of the Federal Department of Home Affairs reserves the right to exclude companies from the Declaration of Milan if they do not demonstrate credible efforts to reduce sugar in the relevant food groups following the criteria established.¹³⁶⁸ Nevertheless, no documented instances of exclusions have been identified, even as sugar levels persist, raising concerns about the criteria’s application and the overall accountability mechanisms in place.

In addition, it has been pointed out that another reason for the limited impact is the methodological approach used to assess compliance, which is based on the overall product portfolio within a given category rather than on individual products..¹³⁶⁹ This allows companies, such as Coca-Cola Schweiz GmbH, to reformulate less prominent products from the brand and not their main product like Coca-Cola Classic.¹³⁷⁰ Furthermore, significant product categories,

¹³⁶³ *ibid.*

¹³⁶⁴ Office Fédéral de la Sécurité Alimentaire et des Affaires Vétérinaires, *Sucres ajoutés dans les yogourts et les céréales pour petit-déjeuner sur le marché suisse (2019)*, August 2019 <<https://www.news.admin.ch/news/message/attachments/58171.pdf>> 22 April 2024.

¹³⁶⁵ Sophie Bucher Della Torre and Corinne Jotterand Chaparro, *Rapport sur la mise en place de mesures visant une réduction de la consommation de sucre* (Haute École de Santé, HES-SO, Genève 2019).

¹³⁶⁶ Office Fédéral de la Sécurité Alimentaire et des Affaires Vétérinaires, *Les entreprises s’engagent à réduire davantage les sucres dans les yogourts et céréales*, 27 août 2019 <<https://www.news.admin.ch/fr/nsb?id=76191>> 22 April 2024.

¹³⁶⁷ *Erklärung von Mailand 2019–2024*, Art 4 lit c.

¹³⁶⁸ *ibid.*

¹³⁶⁹ Marie-Hélène Peter-Spiess, ‘Sucres Ajoutés et Santé Publique: Quelles Perspectives Pour Une Réglementation?’ [2024] Jusletter 146-147.

¹³⁷⁰ *ibid.*

such as sports drinks, known for their high sugar content, are excluded from the Declaration.¹³⁷¹ This omission limits the initiative’s potential impact on overall sugar reduction and suggests a gap in the approach to address comprehensive dietary health.

According to the commitments made by soft drink companies, signatories of the Declaration of Milan were expected to reduce the sugar content in their products by the end of 2024. However, politicians have pointed out significant shortcomings in this voluntary approach.¹³⁷² For instance, in Switzerland, a single Fanta Orange currently contains over 103 grams of sugar, compared to 45 grams in the United Kingdom and 65 grams in France, which are countries that have adopted legislative measures, such as sweetened beverages taxes.¹³⁷³

This significant discrepancy raises important questions about the scientific standards applied within these partnerships. Who decides the amount of sugar in a yoghurt or soda? Where is the scientific evidence coming from? And critically, how can there be such a difference in the sugar content of the same product, such as Fanta Orange, across different countries? Is there not a scientific standard setting? The lack of consistency puts into question whether scientific standards are being selectively interpreted or subordinated to commercial interests, thereby undermining public health objectives.

Despite their commitments, companies rarely provide concrete details on sugar reduction, instead offering vague statements such as having “started reducing sugar content and continuing to do so.”¹³⁷⁴ This brings into question how monitoring is made in this collaboration. In a close analysis of the available information at the Federal Food Safety Veterinary Office, from the first memorandum of understanding from 2015, there are two important failures to highlight. First, do not set any concrete targets and second, there is no mention of how monitoring will be conducted.¹³⁷⁵ In the 2017 version of the agreement, targets were set.

It is important to observe that in the document signed in 2019 to “Extension of the Milan Declaration”, it states that the definitions of targets have been made based on the results of the

¹³⁷¹ *ibid.*

¹³⁷² Radio Télévision Suisse, ‘Les Sodas Suisses Ont-Ils Vraiment Réduit Leur Teneur En Sucre?’ (RTS 2024) <<https://www.rts.ch/info/sante/2024/article/sodas-suisses-reduction-du-sucre-en-question-enquete-et-enjeux-de-sante-28723422.html>> accessed 18 February 2025.

¹³⁷³ Peter-Spiess, ‘Sucres Ajoutés et Santé Publique’ (n 1369)

¹³⁷⁴ RTS, ‘Les Sodas Suisses Ont-Ils Vraiment Réduit Leur Teneur En Sucre?’ (n 1372).

¹³⁷⁵ *Memorandum of Understanding über die Zusammenarbeit im Rahmen der Zuckerreduktion in Joghurts und Frühstückscerealien* zwischen dem Eidgenössischen Departement des Innern (EDI) und bio-familia AG, Bossy Céréales SA, Coop Genossenschaft, Cremo SA, Emmi Gruppe, Migros-Genossenschafts-Bund, Molkerei Lanz AG, Nestlé Suisse SA, Schweizerische Schälzmühle E. Zwicky AG, Wander AG.

current sugar surveys and after “discussions with the companies”.¹³⁷⁶ So, companies have a direct seat at the table here in making the decisions.

Concerning monitoring, the document specifies that monitoring was planned for August 2021 and with this monitoring (for which no information is found on whether it would be based on self-declaration from the industry or inspections), it will be conducted an initial assessment in 2022.¹³⁷⁷ It identifies the questions that serve as an additional basis for discussion in the evaluation: Was the interim target of -8% across all of the company’s breakfast cereals achieved? Was the sugar content reduced in existing products (based on the 2018 survey) that are above the median of the corresponding breakfast cereal category (across all companies)? In newly introduced products relevant for daily consumption (permanent or seasonal), was the level of added sugar below the median value (based on the 2018 survey) of the corresponding breakfast cereal category (across all companies)?

After the monitoring, it established that “an interim assessment” across all companies would be conducted in 2022, and it would communicate the overall status of target achievement within the industry.¹³⁷⁸ Additionally, it affirms that the specific results of individual companies would not be published.¹³⁷⁹ Questions of transparency could be raised here.

According to the report that described the situation in 2021, the content of sugar in yoghurts had fallen by 5.7% (0.5 grams per 100 grams), and that in breakfast cereals had fallen by 13% (1.9 grams per 100 grams) since 2018. Since 2016, the content of sugar in yoghurts had fallen by 8.9% (0.8 grams per 100 grams), and that in breakfast cereals had fallen by 24.3% (4.2 grams per 100 grams).¹³⁸⁰ However, several concerns remain. For example, products aimed at children contain, on average, twice as much sugar as other products.¹³⁸¹

A pediatrician specializing in childhood obesity has emphasized that voluntary measures alone are insufficient to address the issue effectively.¹³⁸² Additionally, on 20 December 2024, a postulate named “Faced with the risk of an obesity epidemic, Switzerland must take more

¹³⁷⁶ Erklärung von Mailand 2019–2024, *Anhang zur Zuckerreduktion in Frühstückscerealien*, Vereinbarung zwischen dem Eidgenössischen Departement des Innern (EDI) und ALDI SUISSE AG u.a. (27 August 2019).

¹³⁷⁷ *ibid.*

¹³⁷⁸ *ibid.*

¹³⁷⁹ *ibid.*

¹³⁸⁰ Esther Infanger, *Sucres ajoutés dans les yogourts et les céréales pour petit-déjeuner sur le marché suisse: État des lieux en 2021 et comparaison avec les résultats des années 2016, 2017 et 2018* (rapport établi pour l’Office Fédéral de la Sécurité Alimentaire et des Affaires Vétérinaires (OSAV), février 2023).

¹³⁸¹ *ibid.*

¹³⁸² RTS, ‘Les Sodas Suisses Ont-Ils Vraiment Réduit Leur Teneur En Sucre?’ (n 1372).

effective measures” was filed.¹³⁸³ The postulate calls on the Federal Council to assess the impact of the measures recommended in the Declaration of Milan and to propose stronger legal regulations. It underscores several key shortcomings of the Declaration, including lack of transparency regarding sugar reduction figures, not all companies participate, or they do so at their own pace, data provided by the industry is grouped by product categories rather than by the number of products sold, many products on the market still contain excessive amounts of sugar compared to recommendations.¹³⁸⁴

4.3 Conclusion

First, despite the collaborative intentions, sugar levels in food products in Switzerland remain alarmingly high. This persistence raises significant concerns regarding the Declaration and the commitment of participating companies to genuinely reduce sugar content in their offerings. Second, the flexibility for companies to terminate their participation without any obligation to provide reasons undermines the stability and accountability of this collaboration. The ability to exit the agreement unilaterally poses questions about compliance and the sincerity of the companies’ commitments, leaving the public health outcomes in jeopardy. Finally, even with the provision of the right to exclude companies, no information has been found of this action happening, thus it remains largely symbolic.

In conclusion, while the Declaration of Milan marks the attempt at a public-private partnership for NCD prevention, in which there is a form of contract. However, it remains vague and incomplete in critical respects. Important details are missing, such as how monitoring is carried out and how standards are defined and enforcing the provisions established.

5 Voluntary Sodium Reduction Goals

5.1 Background

¹³⁸³ Laurence Fehlmann Rielle, “24.4604 Postulat: Face au risque d’épidémie d’obésité, la Suisse doit prendre des mesures plus efficaces” (Parlement Suisse, 20 December 2024).

¹³⁸⁴ *ibid.*

Inspiration model: National Salt and Sugar Reduction Initiative

In 2009, the New York City Health Department launched the National Salt Reduction Initiative (NSRI), a partnership of over 100 local, state, and national health organizations alongside the food industry.¹³⁸⁵ This initiative aimed to establish targets for reducing sodium levels in packaged and restaurant foods. The partnership's primary goal was to urge major food companies to make voluntary commitments to specific sodium reduction targets for various food categories, while also monitoring sodium levels to track progress.¹³⁸⁶ The targets included 62 packaged food categories and 25 categories of restaurant food, ranging from breakfast cereal to burritos, and were established together with the food industry.¹³⁸⁷

The process of setting sodium reduction targets included meetings with the industry to understand their challenges.¹³⁸⁸ A significant issue arose with the FDA's Standards of Identity, which define the specific ingredients required for a product to be labeled as a particular food item.¹³⁸⁹ For example, some types of cheese must contain a certain amount of sodium to legally be called cheese.¹³⁹⁰ This presented a technical challenge, as reducing sodium could alter the product's consistency and even its classification. Thus, the industry has a part in the decision-making process here.

According to the NYC Health Department NSRI, participating companies agreed to "work toward meeting the NSRI targets" with specific food categories, "through a transparent, public process".¹³⁹¹ The form of agreement for sodium involved public pledges from companies. There are a few important points to observe here, it states that companies had the flexibility to commit to all or only some of the categories in which they sold products.¹³⁹² In addition, each commitment included a specified timeline for the company to achieve the NSRI target for a given food category.¹³⁹³ This leaves a broad margin for companies to not include high sodium

¹³⁸⁵ NYC Health, 'National Salt Reduction Initiative: Packaged and Restaurant Food' (*NYC Gov*) <<https://www.nyc.gov/site/doh/health/health-topics/national-salt-reduction-initiative-packaged-food.page>> accessed 21 November 2024.

¹³⁸⁶ *ibid.*

¹³⁸⁷ *ibid.*

¹³⁸⁸ Interview with Teresa Conigliaro and Andrea Sharkey from the NYC Department of Health and Mental Hygiene – City of New York on December 6th 2024.

¹³⁸⁹ U.S. Food and Drug Administration, 'Standards of Identity for Food' (*FDA 2024*) <<https://www.fda.gov/food/nutrition-food-labeling-and-critical-foods/standards-identity-food>> accessed 6 December 2024.

¹³⁹⁰ 21 Code of Federal Regulations, *Part 133 - Cheeses and Related Cheese Products*, chapter 1, subchapter B, parts 131-169 <<https://www.ecfr.gov/current/title-21/chapter-I/subchapter-B/part-133>> accessed 6 December 2024.

¹³⁹¹ NYC Health, 'National Salt Reduction Initiative' (n 1385).

¹³⁹² *ibid.*

¹³⁹³ *ibid.*

products for reformulation, moreover, no compliance mechanisms are described or consequences for not achieving the target.

These voluntary sodium reduction goals varied by category, aiming for approximately a 10% reduction by 2012 (the 2012 targets) and a 25% reduction by 2014 (the 2014 targets). A first study published in 2016 concluded that by 2014, only 1 out of 4 food categories met the 2012 targets, and just 2 categories achieved the 2014 targets. Therefore, the overall progress by 2014 was limited, with a 6.8% significant reduction in SWM sodium density, falling short of the NSRI's 25% reduction goal.¹³⁹⁴

A second study published in 2022 evaluating the sodium reduction in the US food industry concluded that by 2014, 26% of packaged food categories had achieved the 2012 targets, while only 3% had reached the 2014 targets.¹³⁹⁵ Thus, there were modest reductions in sodium during the NSRI period, nevertheless, there was virtually no change following 2014.¹³⁹⁶

In 2018, the initiative expanded its scope to become the National Salt and Sugar Reduction Initiative (NSSRI), and in 2021, it introduced targets for sugar reduction. For sugar reduction, the process of deciding the targets incorporated written feedback from industry stakeholders. Two rounds of proposed targets were shared, and industry feedback was considered to refine and finalize these targets.¹³⁹⁷ Unlike the sodium initiative, no companies had made similar public commitments for sugar.¹³⁹⁸ The NSSRI aims to monitor sugar levels in packaged foods and beverages that contribute the majority of added sugars to the American diet. As with sodium reduction, the initiative encourages food companies to adhere to these new targets voluntarily.

FDA: Voluntary Sodium Reduction Goals

Like Switzerland, the United States has also prioritized voluntary approaches over regulatory measures to prevent non-communicable diseases. Excessive sodium consumption is strongly linked to elevated blood pressure, a significant risk factor for heart disease and stroke.¹³⁹⁹ In the

¹³⁹⁴ Christine J Curtis and others, 'US Food Industry Progress during the National Salt Reduction Initiative: 2009–2014' (2016) 106 *American Journal of Public Health* 1815.

¹³⁹⁵ Alyssa J Moran and others, 'US Food Industry Progress toward Salt Reduction, 2009–2018' (2022) 112 *American Journal of Public Health* 325.

¹³⁹⁶ *ibid.*

¹³⁹⁷ Interview with Teresa Conigliaro and Andrea Sharkey (n 1388).

¹³⁹⁸ *ibid.*

¹³⁹⁹ See Part 1, Chapter 1, 4.3.

American context, over 70% of sodium in the diets comes from processed, packaged, and prepared foods rather than table salt added during cooking or eating at home.¹⁴⁰⁰

To address the issue of salt consumption, the FDA developed a guidance in 2021 that sets voluntary sodium targets to encourage food manufacturers to lower sodium content across the food supply through reformulation. These targets were partially informed by the NSRI and similar voluntary initiatives from other countries.¹⁴⁰¹

The guidance intended to provide measurable voluntary short-term (2.5-year) goals for sodium content in commercially processed, packaged, and prepared foods to reduce excess population sodium intake.¹⁴⁰² The guidance explicitly highlights that it “contains nonbinding recommendations”.¹⁴⁰³

When the guidance was developed, the average sodium intake for Americans 2 years and older was approximately 3,400 milligrams per day (mg/day), while the recommendations of scientific groups suggested to limited sodium intake to about 2,300 mg/day.¹⁴⁰⁴ However, the guidance aimed to reduce the average sodium intake to 3,000 mg/day.¹⁴⁰⁵

The FDA emphasizes that it encourages gradual progress to allow time for product reformulation and for consumers to adjust to new tastes. It suggests that people often fail to notice small reductions (approximately 10 percent) in sodium and that, over time, consumers’ taste preferences adapt to these incremental changes, especially when implemented gradually.¹⁴⁰⁶

In August 2024, the FDA published a draft of a second guidance on Voluntary Sodium Reduction Goals: Target Mean and Upper Bound Concentrations for Sodium in Commercially Processed, Packaged, and Prepared Foods (Edition 2). This new phase, now called Phase II, was built on the Phase I targets issued in 2021. This new phase establishes a new, 3-year

¹⁴⁰⁰ U.S. Food and Drug Administration, ‘Sodium Reduction in the Food Supply’ (*FDA* 2024) <<http://www.fda.gov/food/nutrition-food-labeling-and-critical-foods/sodium-reduction-food-supply>> accessed 4 November 2024.

¹⁴⁰¹ NYC Health, ‘National Salt and Sugar Reduction Initiative (NSSRI)’ (*NYC Gov*) <<https://www.nyc.gov/site/doh/health/health-topics/national-salt-sugar-reduction-initiative.page>> accessed 21 November 2024.

¹⁴⁰² U.S. Food and Drug Administration, ‘Guidance for Industry: Voluntary Sodium Reduction Goals’ (*FDA* 2021) <<https://www.fda.gov/regulatory-information/search-fda-guidance-documents/guidance-industry-voluntary-sodium-reduction-goals>> accessed 4 November 2024.

¹⁴⁰³ *ibid.*

¹⁴⁰⁴ *ibid.*

¹⁴⁰⁵ *ibid.*

¹⁴⁰⁶ FDA, ‘Sodium Reduction in the Food Supply’ (n 1400).

voluntary sodium reduction target for 163 food categories, with the aim of reducing sodium intake to about 2,750 milligrams/day.¹⁴⁰⁷

5.2 Analysis and results

This initiative can be considered a PPP for NCD prevention as it represents a voluntary collaboration between the government and the food industry to prevent NCDs by reducing sodium content in commercially processed, packaged, and prepared foods. The common goal is to reduce the population's sodium intake through reformulation. Whereas in the NSRI, target-setting involved consultation with and incorporation of industry perspectives, it remains unclear to what extent, if any, the food industry was involved in the decision-making process regarding target levels at FDA voluntary sodium Goals.

According to the official document “Voluntary Sodium Reduction Goals: Target Mean and Upper Bound Concentrations for Sodium in Commercially Processed, Packaged, and Prepared Foods: Guidance for Industry”, FDA affirms that it has developed sodium reduction targets for various food categories.¹⁴⁰⁸ These include target mean concentrations and upper bound concentrations. The target mean concentrations are defined as sales-weighted average sodium levels (expressed in milligrams per 100 grams of food) and serve as benchmarks for reformulation within each food category. In determining these targets, the FDA considered the technological feasibility of sodium reduction and the need to preserve essential food safety and functionality roles (e.g., antimicrobial properties). The short-term targets were specifically designed to be achievable using existing technologies and to fall within the range of sodium levels already present in leading commercial products. Finally, the upper bound sodium concentrations (upper bounds) are goals for the highest level of sodium for products in each food category (in milligrams sodium per 100 grams of food).¹⁴⁰⁹

The primary issue with the FDA's sodium reduction target is that it remains above the recommended intake levels outlined in the Dietary Guidelines for Americans, 2020-2025, which recommend less than 2,300 milligrams per day and even less for children younger than age 14.¹⁴¹⁰ The WHO recommends an even stricter limit of less than 2,000 milligrams per day

¹⁴⁰⁷ *ibid.*

¹⁴⁰⁸ FDA, ‘Guidance for Industry: Voluntary Sodium Reduction Goals’ (n 1402).

¹⁴⁰⁹ *ibid.*

¹⁴¹⁰ U.S. Department of Agriculture and U.S. Department of Health and Human Services, *Dietary Guidelines for Americans, 2020-2025* (9th edn., USDA 2020).

(equivalent to under 5 grams of salt).¹⁴¹¹ Therefore, while the voluntary targets aim to encourage a reduction in sodium intake, they still fall short of truly aligning with public health goals and may ultimately be inadequate to safeguard the prevention of chronic diseases.

Secondly, the proposed Phase 2 target, set for 2024, points to a continuing concern: average daily sodium intake in the US remains around 3,400 milligrams. This raises a critical question about the effectiveness of Phase 1, which aimed to lower population sodium intake to around 3,000 milligrams. The persistence of high sodium intake suggests that Phase 1 may not have achieved its intended impact.

Moreover, in its Preliminary Assessment of Progress, the FDA reported that approximately 40% of food categories, including packaged and restaurant foods, had met the Phase I sodium reduction targets or were within 10% of doing so.¹⁴¹² The FDA's optimistic tone here is noteworthy, given that over half of the food categories have not reduced the sodium intake target (which is already above the official recommendations).

Focusing specifically on packaged food categories, over 60% of these categories have seen reductions in sodium content; of these, 30% reduced levels by more than 10%.¹⁴¹³ However, a troubling 25% of categories increased in sodium content, and no change was observed in 12% of categories.¹⁴¹⁴ Looking more closely at specific food categories, the data reveals mixed progress. For instance, among sauces, gravies, dips, condiments, and seasonings, 53% achieved sodium reductions, but 10% remained unchanged, and a concerning 37% saw an increase in sodium levels. In soups, 57% of products showed reductions, while 43% increased their sodium content. Snack foods exhibited somewhat better results, with 64% of products reducing sodium, 18% showing no change, and another 18% increasing sodium levels. Cereals saw a 67% decrease and a 33% increase.¹⁴¹⁵

A recent study critically assessed the FDA's August 2024 update on sodium reduction efforts, noting that while the agency reported directional changes across food categories, it did not indicate the actual magnitude of those changes.¹⁴¹⁶ The study found only a modest median

¹⁴¹¹ World Health Organization, 'Salt Reduction' (*WHO* 2016) <<http://www.who.int/news-room/fact-sheets/detail/salt-reduction>> accessed 4 November 2024.

¹⁴¹² U.S. Food and Drug Administration, 'Sodium Reduction in the U.S. Food Supply 2010-2022' (*FDA* 2024) <<https://www.fda.gov/food/nutrition-food-labeling-and-critical-foods/sodium-reduction-us-food-supply-2010-2022-preliminary-assessment-progress>> accessed 4 November 2024.

¹⁴¹³ *ibid.*

¹⁴¹⁴ *ibid.*

¹⁴¹⁵ *ibid.*

¹⁴¹⁶ Aviva A Musicus and others, 'Appraising the FDA's Sodium Reduction Efforts' (2025) 333 *JAMA*.

reduction of 3% across all the food categories and that sodium levels increased by 25% or more in 11 categories (mainly restaurant foods).¹⁴¹⁷ Finally, only seven categories showed comparable reductions.¹⁴¹⁸

The monitoring of the sodium reduction plan is done by the FDA and other government agencies, such as the US Department of Agriculture and the Centers for Disease Control and Prevention. The FDA affirms that it also actively engages with food manufacturers to learn about their sodium reduction efforts.¹⁴¹⁹

In January 2025, a group of non-government organizations and public health advocates submitted a formal comment to the second edition of the FDA's Draft Guidance of the: Voluntary Sodium Reduction Goals. In this comment, the experts in nutrition science and policy, highlighted several critical points concerning the FDA's sodium reduction efforts. They called for more aggressive targets and highlighted the importance of establishing a timely, transparent, and methodologically rigorous system for monitoring and evaluating progress. In addition, emphasized that the FDA should engage more actively and transparently with the food industry and should urge companies to publicly commit to sodium reduction targets. Finally, the advocates recommended that, should the voluntary Phase II targets remain unmet, the FDA should seriously consider adopting mandatory sodium reduction standards to ensure a meaningful public health impact.¹⁴²⁰

5.3 Conclusion

The lack of enforcement mechanisms means that adherence relies solely on industry willingness. Notably, despite a substantial portion of targets not being met, the FDA has not provided any formal assessment or public disclosure regarding industry non-compliance.

In reality, the FDA extended its voluntary guidance, introducing new targets. Yet this continuation of voluntary measures, despite mixed results, raises questions about the FDA's approach. By choosing to extend the program without adjustments to its voluntary nature, the

¹⁴¹⁷ *ibid.*

¹⁴¹⁸ *ibid.*

¹⁴¹⁹ FDA, 'Sodium Reduction in the Food Supply' (n 1400).

¹⁴²⁰ Center for Science in the Public Interest and others, Comments on FDA Draft Guidance for Industry: Voluntary Sodium Reduction Goals, Second Edition (January 2025) <https://www.apha.org/getcontentasset/37511b92-6e3a-4339-927e-a6bbb27daca7ca0dc9d-611d-46e2-9fd3-26a4c03ddcbb/250113_fda_sodium_reduction_comments.pdf?language=en> accessed 23 June 2025.

FDA may have overlooked the limitations of relying on voluntary compliance to meet critical public health goals.

III Nutri-Score: a public scheme voluntarily adopted by industry that falls short of the definition of a PPP for NCD prevention

1 Background

Nutri-Score is a front-of-package labelling system developed in France which is a color-coded system ranging from A (green), indicating the healthiest options, to E (red), representing foods with lower nutritional value, calculated per standard portion.¹⁴²¹ The Nutri-Score was developed by the French Public Health Institute (Santé Publique France), based on academic work, without the interference of private actors.¹⁴²²

Nutri-Score was first implemented in France in October 2017, where it was introduced and promoted by the French Ministry of Health and the French Public Health Institute.¹⁴²³ At first, the system encountered significant resistance from the food industry, which sought to implement alternative FOP labeling schemes such as the Evolved Nutrition Label from Nestlé, Mars, Coca-Cola, Unilever, Mondelez, and PepsiCo or the Italian NutrInform Battery system.¹⁴²⁴

Initially, no companies adopted Nutri-Score. However, following its official endorsement by the French Ministry of Health in 2017, six industries implemented the system.¹⁴²⁵ Within three months of this official adoption, 33 private entities, including retailers and food manufacturers, had adopted Nutri-Score.¹⁴²⁶ In 2019, Nestlé, one of the biggest opponents to the system, adopted Nutri-Score across its products throughout Europe.¹⁴²⁷ Currently, the Nutri-Score is the

¹⁴²¹ Office Fédéral de la Sécurité Alimentaire et des Affaires Vétérinaires, *Nutri-Score: manger équilibré, tout simplement* <<https://www.blv.admin.ch/nutri-score-fr>> accessed 24 April 2024.

¹⁴²² Serge Hercberg, *Mange et Tais-Toi: Un Nutritionniste Face Au Lobby Agroalimentaire* (humensciences 2022) 230-231.

¹⁴²³ Santé Publique France, 'Nutri-Score' (Santé Publique France 2025) <<https://www.santepubliquefrance.fr/en/nutri-score>> accessed 8 July 2025.

¹⁴²⁴ Hercberg, *Mange et Tais-Toi* (n 1422) 230-231.

¹⁴²⁵ *ibid*, 242.

¹⁴²⁶ Santé Publique France, *Trois mois après son lancement, 33 entreprises de l'agro-alimentaire et de la grande distribution déjà engagées dans le Nutri-Score* (Santé Publique France 2018) <<https://www.santepubliquefrance.fr/presse/2018/trois-mois-apres-son-lancement-33-entreprises-de-l-agro-alimentaire-et-de-la-grande-distribution-deja-engagees-dans-le-nutri-score-R>> accessed 05 August 2024.

¹⁴²⁷ Hercberg, *Mange et Tais-Toi* (n 1422) 242.

FOP scheme adopted by France, Belgium, Germany, Spain, the Netherlands, Luxembourg, and Switzerland.¹⁴²⁸

It has been adopted on a voluntary basis by a large number of private actors (the food industry). In order to use the Nutri-Score, food companies must register with “Santé Publique France” and agree to the terms and conditions governing its use.¹⁴²⁹ Once registered, companies are provided with a Nutri-Score calculation tool and guidelines, allowing them to independently assign and display the Nutri-Score logo on their products.¹⁴³⁰ The OECD estimated that by 2020, over 400 food companies had adopted the Nutri-Score, representing roughly 50% of the market share in sales volume, and by 2021, this number had increased to around 600 companies.¹⁴³¹

The European Commission announced in 2020 that it would propose legislation for a mandatory, harmonized FOP label by 2022.¹⁴³² The European Commission considers Nutri-Score as voluntary information under Art. 36 of the FIC Regulation.¹⁴³³ However, in March 2025, the Commission abandoned Nutri-Score and failed to propose legislation.¹⁴³⁴

2 Analysis and Results

A 2017 study concluded that the Nutri-Score proved effective in improving the nutritional quality of the food chosen by consumers. This shift toward healthier options was especially significant among low-income populations. Moreover, after the implementation of Nutri-Score, sales data in supermarkets in France and Spain showed a decrease in the sales of food products D and E and an increase in sales of food products A and B.¹⁴³⁵

¹⁴²⁸ Julia Chantal and others, ‘Ten Years of Nutri-Score Front-of-Pack Nutrition Labelling in Europe’ (2025) 6 *Nature Food* 239.

¹⁴²⁹ OECD, *Healthy Eating and Active Lifestyles* (n 1332).

¹⁴³⁰ *ibid.*

¹⁴³¹ *ibid.*

¹⁴³² Chantal, ‘Ten Years of Nutri-Score’ (n 1428).

¹⁴³³ Andreas Meisterernst and Leonie Evans, ‘Union Law Basis and Official Controls of the Nutri-Score’ (2020) 15 *European Food and Feed Law Review* 202.

¹⁴³⁴ Food Navigator, ‘Has the European Commission Abandoned NutriScore?’ (*Food Navigator* 2025) <<https://www.foodnavigator.com/Article/2025/03/04/has-the-european-commission-abandoned-nutriscore/>> accessed 8 July 2025.

¹⁴³⁵ European Group of Scientists and Health Professionals in Support of NutriScore (GESHPSN), *Why the European Commission Must Choose the Nutri-Score Nutrition Label*, (Nutri-Score Europe 2023) <<https://nutriscore-europe.com/https-nutriscore-europe-com-wp-admin-post-phppost10actionedit/>> accessed 8 July 2025.

Moreover, Nutri-Score has an impact on food industry practices. For instance, the adoption of the Nutri-Score in Belgium resulted in significant reformulation of breakfast cereal products. A study has shown that between 2017 and 2018, to avoid a bad score of the Nutri-Score FOPL, there were reductions in the total and sodium content and increases in fiber and proteins.¹⁴³⁶ Moreover, in a comparison or reformulation of products with Nutri-Score and their nutrient content in 2019 (year of implementation of Nutri-Score in Belgium) and 2021, the results showed a significant decrease in the median energy content of dairy, sauces, and meat products and the median sugar content of dairy and fruit and vegetable products and a substantial increase in the median fiber content of the dairy, meat products, and non-alcoholic beverages. However, the salt content of the products in 2019 and 2021 was not significantly different.¹⁴³⁷

The Nutri-Score algorithm has received some criticism.¹⁴³⁸ Therefore, efforts are underway to refine the Nutri-Score algorithm in response to criticisms. In 2023, the Nutri-Score European Scientific Committee proposed an algorithm evolution to bring the logo more in line with the different countries' dietary guidelines, better account for scientific knowledge, and adapt to changes in the food supply. The new algorithm started to be gradually implemented in France from spring 2024.¹⁴³⁹

However, after a recalculation of the algorithm, some food corporations decided to abandon the Nutri-Score. For instance, with the new algorithm, many of Danone's dairy and plant-based drinkable products received less positive ratings, and as a result the company removed the label from its products.¹⁴⁴⁰

Similarly, in Switzerland, major companies like Migros and Emmi decided to abandon Nutri-Score in May 2024. Both cited increased costs and a perceived lack of consumer efficiency as justification for their decisions.¹⁴⁴¹ Nonetheless, it is essential to note that the decisions were made after the algorithm was recalculated.

¹⁴³⁶ Marie Vermote and others, 'Nutritional Content, Labelling and Marketing of Breakfast Cereals on the Belgian Market and Their Reformulation in Anticipation of the Implementation of the Nutri-Score Front-Of-Pack Labelling System' (2020) 12 *Nutrients* 884.

¹⁴³⁷ Maria Salve Vasquez and Stefanie Vandevijvere, 'Potential Reformulation of Food Products Two Years after Implementation of Nutri-Score in Belgium' (2024) 34 *European Journal of Public Health*.

¹⁴³⁸ Daniela Martini and others, 'Relationship between Front-of-Pack Labeling and Nutritional Characteristics of Food Products: An Attempt of an Analytical Approach' (2022) 9 *Frontiers in Nutrition*.

¹⁴³⁹ Santé Publique France, 'Nutri-Score' (n 1423).

¹⁴⁴⁰ Augustus Bambridge-Sutton, 'Why Is Danone Removing Nutri-Score?' (*Food Navigator* 2024) <<https://www.foodnavigator.com/Article/2024/09/13/Danone-removes-Nutri-Score>> accessed 17 October 2024.

¹⁴⁴¹ ATS Agence télégraphique suisse, 'Après Migros, Un Autre Mastodonte Abandonne Le Nutri-Score' (*Blick* 2024) <<http://www.blick.ch/fr/suisse/apres-migros-le-groupe-emmi-leader-de-lindustrie-laitiere-va-lui-aussi-abandonner-le-nutri-score-id19771843.html>> accessed 4 November 2024.

3 Nutri-Score beyond the scope of PPP for NCD prevention

The Nutri-Score is a public scheme adopted on a voluntary basis by industries. Thus, it falls short of qualifying as PPP for NCD prevention within the definition here adopted.¹⁴⁴² There are certain similarities; however, it does not meet the key structural elements of PPPs. In particular, it lacks the notion of the public and private sectors coming together for public health promotion. One could interpret that the public and private sectors indirectly align around public health objectives and NCD prevention through the scheme, but this does not amount to the joint initiative characteristic of PPPs.

As of now, for being voluntary, it is indirectly a voluntary collaboration between the public sector (government entities) and the for-profit private sector (food industry) to address the challenges imposed by NCDs through public education and information and product reformulation. In this case, public health promotion occurs through public information (providing consumers with easier information concerning nutritional labelling) to understand the nutritional content and encourage consumers to adopt healthier options. In addition to matching a good score in this system evaluation, many companies are reformulating their products (less sugar or sodium, for instance), which increases healthier food choices for consumers.

It is interesting to compare Nutri-Score to the Danish Whole Grain logo. In both cases, companies reformulate their products to meet the criteria required to display the logo. In the case of Nutri-Score, the food industry is incentivized to reformulate its products to achieve a good score within the system. However, the Nutri-Score does not have an institutional board, and companies do not have a say on the science determining the label. Thus, the element of shared decision-making is not present here, since the scientific criteria underpinning the Nutri-Score system were developed independently by public health authorities, without industry influence. Implementation, while voluntary, is carried out unilaterally by private actors based on an established system.

Therefore, Nutri-Score does not qualify as a PPP for NCD prevention, nor as self-regulation, since the scheme was not initiated by the industry. It also does not constitute a command-and-

¹⁴⁴² Part 3, Chapter 10, 3 Definition.

control measure, as it remains voluntary, unlike the mandatory FOP schemes adopted in several Latin American countries.

IV Comparative analysis: PPPs for NCD prevention vis-à-vis PPPs in general and global health PPPs

In examining PPPs for non-communicable disease prevention alongside traditional PPPs and global health PPPs, key differences emerge.

First, PPPs for NCD prevention maintain the idea of being a voluntary agreement between the public sector (government) and private sector (food industry) to achieve a common goal via some degree of shared decision-making. However, the issues raised about the common goal and alignment of the food industry already challenge the structural components of the definition of PPPs.

Traditional PPPs generally share a clear, common objective. For instance, in infrastructure projects, public entities and private parties are committed to tangible outcomes, such as building roads, with aligned incentives and defined mutual benefits. Along the same lines, in global health public-private partnerships, the public and private sectors share the goal of improving the population's health through mutually agreed roles. In the new format of global health PPPs, the idea of a common goal starts to come into question. To what extent does the food industry have the common goal to combat undernutrition? Or is this seen as an opportunity to improve the public image of the food corporation while spreading their brand and products? Thus, industry misalignment starts to appear. This is emphasized in PPPs for NCD prevention, where multinational food corporations, partners in PPPs for NCD prevention, lack a unified commitment to public health. Conflicts of interest arise when corporate priorities, like profit maximization by selling unhealthy products, do not align with health promotion.¹⁴⁴³ Thus, these PPPs end up defying their normative purpose.¹⁴⁴⁴

Furthermore, in the definition of PPPs in general, there is the notion of “shared benefits and risks”. In PPPs for NCD prevention, the “shared benefits and risk” becomes problematic, since the food industry does have a benefit but does not have a risk. On the other hand, the public sector does have a risk for NCD prevention, and the public health benefit is lacking. The

¹⁴⁴³ Stevenson, ‘The Relevance of the Public–Private Partnership Paradigm’ (n 1019).

¹⁴⁴⁴ See Chapter 11, II The promotion of public health by private actors.

element of “shared decision-making” is present, since food corporations, in most cases, have a seat at the table in defining the targets. Thus, PPPs for NCD prevention already differ in structural components of the definition.

A key difference also lies in the legal framework underpinning each type of PPP. Traditional PPPs generally include clear, contractual agreements governed by mostly administrative law. These agreements are structured with compliance mechanisms and legal tools, setting obligations for the private sector. If, for example, a construction company fails to meet contractual obligations in building infrastructure, the private-sector firm bears the risks and will be affected by the consequences. Conversely, in PPPs for NCD prevention, compliance rules are frequently absent or vague. If the multinational food corporations do not meet reformulation targets there are often no penalties, as seen in the Declaration of Milan and the Voluntary Sodium Target Goals in the US, which, despite repeated failures to achieve their objectives, have been continuously renewed and extended.

This contrast underscores a key divergence: while a well-designed legal framework is critical for traditional PPPs, its role is much less defined in PPPs for NCD prevention. These partnerships operate in a regulatory gray zone, lacking reliance on established legislation and non-binding guidelines or soft-law instruments. This absence of a legal framework poses significant challenges to establishing, implementing, and sustaining such partnerships.

One key concern with PPPs in general, global health PPPs, and PPPs for NCD prevention is the concern of the blur of boundaries between private and public spheres and the promotion of public goods by private actors. This is a common characteristic of this approach overall.

Achieving outcomes is another crucial difference between traditional PPPs, global health PPPs, and PPPs for NCD prevention. Traditional PPPs, in the majority of cases, achieve the expected outcomes, as seen in initiatives like Operation Warp Speed in the US, which accelerated COVID-19 vaccine development.¹⁴⁴⁵ Although criticized for allowing corporations to maintain their influence in global health governance, global health PPPs have also been proven effective in raising awareness of pressing health issues, securing funding, and mobilizing resources for neglected diseases. These partnerships have also played a crucial role in developing and

¹⁴⁴⁵ Evidently, not all cases of PPPs in their generic form are successful. However, this thesis does not explore these aspects in detail. For case studies, see Felix I Lessambo, *International Project Finance: The Public-Private Partnership* (Palgrave Macmillan 2022) 173-198.

delivering essential health products, including over 50 vaccines and 25 drugs targeted at diseases primarily affecting low-income populations.¹⁴⁴⁶

By contrast, PPPs for NCD prevention have largely failed to deliver substantial public health benefits.¹⁴⁴⁷ As illustrated in the case studies, structural weaknesses and unaddressed conflicts of interest compromise the potential of these partnerships to achieve meaningful public health gains. For instance, empirical evidence shows that the Responsibility Deal failed to meet its targets.¹⁴⁴⁸ In addition, my analysis, combined with existing literature, of selected case studies, reveals that agreements such as the Declaration of Milan and the US Voluntary Sodium Target Goals have not significantly reduced sugar and salt levels in packaged products.

Furthermore, there is a wide diversity in the types of PPPs for NCD prevention, with significant variation in their structure (how the industry engages) and decision-making dynamics. For instance, the Declaration of Milan, grant industry representatives a seat at the table, allowing them to shape key decisions, including the extent of product reformulation and it was established through a memorandum of understanding, reflecting a negotiation solution, whereas the Danish Whole Grain Partnership follows a more formalized structure, with a board of representatives resembling the governance model of global health partnerships.

Overall, traditional PPPs remain a reliable mechanism for infrastructure financing due to their effectiveness, robust legal frameworks, and enforceable compliance measures. Similarly, GPPPs, supported by formalized roles and institutionalized character, have contributed significantly to global health initiatives. However, the lack of formalized agreements in NCD prevention PPPs results in poorly defined roles and limited accountability, making it challenging to enforce compliance. In addition, the inherent conflict of interest in this scenario and the industry misalignment with the common goal raise important questions about these partnerships as an alternative regulatory tool to command-and-control regulations to NCD prevention.

¹⁴⁴⁶ Ruckert and Labonté, 'Public-Private Partnerships (PPPs) in Global Health' (n 1098).

¹⁴⁴⁷ In this context, effectiveness would refer to the ability of the PPP to achieve its stated public health objectives, namely, the prevention of NCD through the reformulation of food products to reduce levels of critical ingredients such as sodium or sugar. This definition emphasizes outcomes, as the key criterion for evaluating the PPP's success.

¹⁴⁴⁸ Knai and others, 'Has a Public-Private Partnership Resulted in Action' (n 1292).

CHAPTER 11: LEGAL SCRUTINY OF PPPs FOR NCD PREVENTION

I Preliminary remarks

As has been pointed out by the former Executive Vice President of Global Corporate Affairs for Kraft Foods, PPPs aim to enhance the industry's reputation and strengthen brand loyalty.¹⁴⁴⁹ In his words: "Next time you hear of a big food or beverage company sponsoring an after-school physical activity program in your community, you can be sure they'll say it's to show 'our company's concern for our kids' health." But the real intent is to look angelic while making consumers feel good about the brand and drawing attention away from the unhealthful nature of the company's products."¹⁴⁵⁰

Public-private partnerships for non-communicable disease prevention present numerous legal concerns that range from normative questions to practical issues. This section delves into these complexities, focusing on the principal question and foundation of the discussion of the role of private actors in advancing public health, and then moves to practical issues such as conflicts of interest and lobbying as a regulation avoidance mechanism.

First, the involvement of private actors in public health prompts critical questions about the delegation of public goods to the private sector. A central question emerges: Can the promotion of public health by NCD prevention be advanced by private actors such as transnational companies? if so, within what limits should states delegate public goods and services to private entities? Additionally, what are the criteria for deciding which functions can be shifted to the private sector? These are key issues in assessing the viability and limitations of PPPs in the realm of NCD prevention.

Second, conflicts of interest are a major concern, particularly when the private sector includes industries whose products contribute to NCDs. The tension between public health goals and the profit-driven motives of private companies may jeopardize the credibility and effectiveness of health promotion efforts.

Finally, the issue of lobbying adds another layer of complexity. Corporations, especially those in the food and sugar-sweetened beverage industries, wield substantial influence over public policy. This influence can shape public health regulations and priorities, often directing them

¹⁴⁴⁹ Marks, 'Toward a Systemic Ethics of Public-Private Partnerships' (n 35).

¹⁴⁵⁰ *ibid.*

to favor corporate interests over public health objectives. A specific facet here is the use of lobbying to favor PPPs for NCD prevention as an avoidance mechanism to regulation.

II The promotion of public health by private actors

1 Introduction

Grounded in neoliberal principles, the new public management movement, and the idea of the public sector's inefficiency, PPPs have emerged as an alternative tool for enhancing efficiency in addressing various public services. Nevertheless, public-private partnerships in all fields (from administrative law to public health law) redraw the boundaries of the public-private dichotomy, blending their roles and imposing normative legal questions about public duties and functions.¹⁴⁵¹

Regarding public health, there are instances where private actors, including transnational companies, actively participate in the provision of public goods.¹⁴⁵² For example, pharmaceutical companies contribute to developing and distributing vaccines and medicines. The COVID-19 pandemic heightened their role.¹⁴⁵³ However, concerns arise when profit motives clash with public health goals.

Health has traditionally been acknowledged as a public good, and the right to health has been recognized as a human right. States, as human rights bearers, have tripartite obligations to protect, fulfill, and respect the right to health.¹⁴⁵⁴ Under international human rights law, the legal responsibility of States remains even in the case of delegating to private actors (under privatization) or sharing (in the PPP system).¹⁴⁵⁵ On the other hand, international human rights obligations do not traditionally apply to private actors.¹⁴⁵⁶

Despite debates, it is evident that PPPs are enduring and expanding into diverse domains. In addition, although controversial, the privatization of public services has occurred across

¹⁴⁵¹ The analysis here focuses specifically on PPPs in the context of NCD prevention.

¹⁴⁵² Andreas Georg Scherer and Guido Palazzo, 'The New Political Role of Business in a Globalized World: A Review of a New Perspective on CSR and Its Implications for the Firm, Governance, and Democracy' (2011) 48 *Journal of Management Studies* 899.

¹⁴⁵³ See Part 3, Chapter 9 and the example of Operation Warp Speed in the US.

¹⁴⁵⁴ See Part 2, Chapter 4, II

¹⁴⁵⁵ Koen De Feyter and Felipe Gómez Isa, *Privatisation and Human Rights in the Age of Globalisation* (Intersentia 2005) 3.

¹⁴⁵⁶ Part 4, Chapter 12, I, 4.1.

different sectors. Privatization is not a new phenomenon. For instance, many countries adopted the privatization of public services such as public education and health systems.

Privatization has been described as “the act of reducing the role of government, or increasing the role of the private sector, in an activity or the ownership of assets”.¹⁴⁵⁷ In addition, privatization has been defined in two primary ways: “any shift of activities or functions from the state to the private sector; and, more specifically, any shift of the production of goods and services from public to private”.¹⁴⁵⁸ Finally, it can be understood as a “situation where services previously provided by a public body are now provided by a private body on the basis of an agreement with the public sector”.¹⁴⁵⁹

One of the main challenges of privatization is maintaining transparency, fairness, and accountability.¹⁴⁶⁰ Accountability is a crucial element that becomes blurry in the context of PPPs. In the privatization scenario, accountability has been an issue from the international human rights perspective.¹⁴⁶¹

Concerning the public health system, privatization has primarily manifested in various aspects of healthcare services. As Tobes highlighted, “the right to health may be satisfied through whatever mix of public and private services are appropriate in the national context”.¹⁴⁶² In addition, the author calls attention to the fact that General Comment 14 stresses that under the obligation to protect, States have to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability, and quality of health facilities, goods, and services.¹⁴⁶³ Clearly, here the mention is related to the healthcare sector. However, it is possible to extend the parallel to broader public health promotion efforts.

Privatization within the public health sector is undeniable and increasingly involves private actors, including transnational companies, in roles traditionally held by the state. Therefore, to answer the question of whether private actors can advance the promotion of public health through public-private partnerships in a straightforward manner, the answer would be yes, because it has already been occurring. Then, the challenging questions are:

¹⁴⁵⁷ Kitsos, ‘Privatisation and Public Private Partnerships’ (n 1043).

¹⁴⁵⁸ *ibid.*

¹⁴⁵⁹ Feyter and Gómez Isa, *Privatisation and Human Rights in the Age of Globalisation* (n 1455) 35.

¹⁴⁶⁰ *ibid.*

¹⁴⁶¹ *ibid.*, 221-222.

¹⁴⁶² Brigit Toebes, ‘The Right to Health and the Privatization of National Health Systems: A Case Study of the Netherlands’ (2006) 9 *Health Hum Rights* 102.

¹⁴⁶³ CESCR, ‘*General Comment No. 14*’ UN Doc E/C.12/2000/4 (n 406) para 35.

- A) What are the limits of the public goods that a State can delegate to private parties?
- B) Additionally, what are the criteria for deciding which functions can be shifted to the private sector?
- C) What are the safeguards necessary for such a public health framework to succeed?

The first two questions address long-standing debates surrounding the public-private dichotomy and the classification of health as a public good. While these issues have no definitive answers, this thesis does not aim to resolve or delve deeply into them.¹⁴⁶⁴ Instead, it seeks to explore how the public-private dichotomy is visible in public-private partnerships and how this mechanism defies its intended purpose in the context of NCD prevention.

Health is among the goods that have traditionally been considered a public good.¹⁴⁶⁵ However, nowadays, there are mechanisms such as public-private partnerships that allow sphere transgressions between the public and private spheres. The analysis will focus on two critical points: (1) allowing private actors to decide about public health objectives; and (2) PPPs typically are justified due to their efficiency in delivering public services (which is the case for infrastructure projects), however in the context of NCD prevention, as shown within the case studies, they mostly fall short of effectively promoting public health and preventing NCDs therefore defying its normative purpose.¹⁴⁶⁶

To provide a deeper understanding of these issues, this thesis will further examine the public-private dichotomy, clarifying the distinctions and potential overlaps between these spheres. This discussion will be enriched by an analysis of WALZER's Spheres of Justice, particularly his concept of the autonomy of spheres. This theoretical lens will help illuminate the risks associated with involving private actors in public health initiatives, critically assessing the premise that PPPs are an optimal regulatory alternative in the legal architecture of NCD prevention.

2 Public-private dichotomy

¹⁴⁶⁴ The last question will be addressed in the last part of this thesis.

¹⁴⁶⁵ This thesis will not further explore the discussion of why health is considered a public good.

¹⁴⁶⁶ See Chapter 10, III, for an analysis of concrete examples of the failure of PPPs in addressing public health promotion.

2.1 Blurring boundaries between public and private

The public-private dichotomy has long been a subject of debate among American Legal Thought scholars, particularly in the context of the privatization of public services. One of the most complex questions within this discourse is determining where the line between public and private is drawn.¹⁴⁶⁷ The evolving landscape of public-private partnerships blurs the distinction between public and private spheres.

For instance, SHAMIR underscores that the public/private distinction and the content of each sphere, their stability as distinct spheres, and their interaction with each other have significantly changed in the twenty-first century, highlighting the phenomena of privatization and the increased visibility of the interconnectedness of the spheres.¹⁴⁶⁸

VERKUIL observes that the “public interest has historically justified government intervention in liberal democracies, especially in the American context, with agencies empowered since the nineteenth century to uphold the public interest, convenience, and necessity”.¹⁴⁶⁹ Yet, he raises important questions about delegating this authority to private actors: Should public law mechanisms, such as oversight and accountability, extend to these private entities? Should private parties have the right to wield public power? Such rule-of-law considerations are crucial for defining boundaries between public and private.¹⁴⁷⁰

VERKUIL further argues that the public-private distinction remains vital for setting limits on the transfer of political power to private hands.¹⁴⁷¹ As he observes, assessing the boundaries of privatization requires considering whether “inherent functions” of government are being delegated. US law, for instance, identifies certain nondelegable duties, particularly where key governmental powers must be exercised by officials who have taken an oath to uphold the Constitution.¹⁴⁷² For example, the Secretary of Defense cannot outsource war conduct decisions to a private entity like the Rand Corporation.¹⁴⁷³ In these instances, core responsibilities remain strictly within the government’s hands to ensure proper exercise and oversight of authority.¹⁴⁷⁴

This principle can be analogously applied to the role of multinational food corporations in public health decisions. While it seems unthinkable to allow the arms industry to decide on

¹⁴⁶⁷ Paul R Verkuil, ‘Public Law Limitations on Privatization of Government Functions’ (2006) 84 North Carolina Law Review.

¹⁴⁶⁸ Shamir, ‘The Public/Private Distinction Now’ (n 36).

¹⁴⁶⁹ Verkuil, ‘Public Law Limitations on Privatization of Government Functions’ (n 1467).

¹⁴⁷⁰ *ibid.*

¹⁴⁷¹ *ibid.*

¹⁴⁷² *ibid.*

¹⁴⁷³ *ibid.*

¹⁴⁷⁴ *ibid.*

matters of national defense, we often accept that the food industry should play a role in determining regulations for products that impact public health, such as the amount of sugar in their unhealthy products. This parallel raises a key question: Why are industries that contribute to major public health issues allowed such influence over regulatory decisions when similar influence in other areas, like defense, would be deemed unacceptable?

2.2 The regulatory welfare state and the transformation of public functions

As SHAMIR argued, the welfare state is undergoing a profound transformation.¹⁴⁷⁵ She describes the emergence of a “regulatory welfare state” that does not simply delegate former state functions to the private market but actively redefines the boundaries and content of public and private spheres. This shift blurs the line between these domains, challenging the traditional concept of their separateness and presumed dichotomous nature.¹⁴⁷⁶ As SHAMIR observes, this entanglement complicates the “institutional DNA” of each sphere, raising new questions about their distinctive core and stable, predetermined functions.¹⁴⁷⁷

In the current context, various public goods have been delegated to the private sector, exemplified by the privatization of healthcare services in many countries. This trend is rooted in ongoing privatization, underpinned by the belief that governments are often inefficient in managing certain services. The narrative supporting this idea frequently emphasizes the private sector’s role in driving innovation.¹⁴⁷⁸

This trend extends to public health promotion, where “new governance” theory influenced the implementation of voluntary approaches such as PPPs for NCD prevention. Examples include the adoption of voluntary agreements by different countries to reduce sodium and sugar consumption. These strategies reflect the increasing involvement of private actors in shaping public health initiatives, which has implications for the limits of state responsibility in safeguarding the public good. Scholars in other areas of law have noted this evolution, describing contemporary regulatory regimes as “mixed administration, in which private actors and government share regulatory roles.”¹⁴⁷⁹

¹⁴⁷⁵ Shamir, ‘The Public/Private Distinction Now’ (n 36).

¹⁴⁷⁶ *ibid.*

¹⁴⁷⁷ *ibid.*

¹⁴⁷⁸ Tamar Sharon, ‘Blind-Sided by Privacy? Digital Contact Tracing, the Apple/Google API and Big Tech’s Newfound Role as Global Health Policy Makers’ (2020) 23 *Ethics and Information Technology* 45.

¹⁴⁷⁹ Jody Freeman, ‘Private Parties, Public Functions and the New Administrative Law’ (1999) 52 *Administrative Law Review*.

However, as LOCKE pointed out long ago, “legislation cannot be privatized.”¹⁴⁸⁰ In addition, it has been argued in the discussion of the public-private dichotomy that there are functions in which the public actor is not fungible or replaceable, such as functions tied to policymaking.¹⁴⁸¹ Moreover, it has been argued that some governmental decisions simply cannot be successfully executed by private entities since the public goods resulting from these decisions can be realized only if the state performs these tasks, and second, execution by the state requires performance by public officials.¹⁴⁸²

2.3 Regulatory capture and the limits of PPPs for NCD prevention

Building on this idea, it can be argued that in PPPs for NCD prevention, one limit would be that the private sector should not have a role in the decision-making process. For example, setting specific health targets, such as sodium reduction limits, should be a decision made solely by public authorities, leaving private actors to meet the established targets rather than setting them. Allowing private actors to play a role in decision-making risks broad or vague targets that may fall short of critical public health objectives.

It is discussable that this limitation could alter a core element of PPPs in their original format, where private actors typically have a more active role in shaping goals (decision-making processes). However, PPPs for NCD prevention already diverge from the traditional PPP model.¹⁴⁸³ Therefore, limiting private sector influence over decision-making would not fundamentally alter the nature of these partnerships but rather adapt them to better align with public health priorities.

From a different standpoint, if we acknowledge that the private sector is taking on new roles within this “mixed regulatory regime,” it becomes essential to establish mechanisms that safeguard the public interest (public health). From an administrative law perspective, for example, the US has developed various oversight mechanisms (legislative, executive, and judicial) to discipline agency behavior to ensure accountability and legality.¹⁴⁸⁴

Similarly, FREEMAN, in analyzing the privatization of social services, highlights that the absence of a direct government role does not imply that the “private regime is free of

¹⁴⁸⁰ John Locke, *Locke: Two Treatises of Government* (Peter Laslett ed, Cambridge University Press 1988) §41.

¹⁴⁸¹ Verkuil, ‘Public Law Limitations on Privatization of Government Functions’ (n 1467).

¹⁴⁸² Avihay Dorfman and Alon Harel, ‘The Case against Privatization’ (2013) 41 *Philosophy & Public Affairs* 67.

¹⁴⁸³ Part 3, Chapter 10, III Comparative analysis: PPPs for NCD prevention vis-à-vis PPPs in general and global health PPPs and Annex 1: Table: Comparative Taxonomy of PPP.

¹⁴⁸⁴ Freeman, ‘Private Parties, Public Functions and the New Administrative Law’ (n 1479).

regulation.”¹⁴⁸⁵ Even without formal government intervention, informal regulatory frameworks can emerge, imposing standards and practices.¹⁴⁸⁶ FREEMAN suggested that we might extend existing oversight mechanisms and procedural controls, typically applied to government agencies, to private actors, essentially treating them as “public” entities when performing functions traditionally within the state’s domain.¹⁴⁸⁷ This model reflects a broader trend of privatization while maintaining regulatory oversight to ensure accountability.¹⁴⁸⁸ The same can be argued in the context of public-private partnerships, even if they are based on voluntary agreements, informal regulatory tools may be adopted to maintain oversight to ensure accountability.

Nonetheless, the appropriate limits for private involvement in managing public goods remain ambiguous, particularly as boundaries between the public and private spheres continue to blur.

In the context of PPPs for NCD prevention, private sector engagement hinges on the alignment of public health goals with business interests.¹⁴⁸⁹ Private actors may have limited motivation to engage meaningfully without a clear benefit. One strategy can be the threat of applying (financial) penalties or leveraging command-and-control regulatory measures. Lessons from PPPs in other sectors underscore the value of clear regulatory structures and incentives to maintain effective collaborations. For instance, in the field of administrative law, it has been identified that public-private arrangements are more accountable because of the agency’s threat of regulation, which provides the necessary motivation for the effective involvement of non-movement actors.¹⁴⁹⁰

PPPs for NCD prevention add a new layer of complexity due to the inherent conflict of interest of the private sector involved. Thus, in this context, private parties should not have control over fundamental decision-making in public health. Partnering with food industries has allowed these stakeholders to shape the regulatory approach to NCD prevention. This resulted in regulatory a “gray zone” towards the food industry in the context of unhealthy diets and NCD prevention that accommodates industry interests at the expense of robust public health protections. This dynamic not only produces regulatory gaps but also aligns public policies with corporate priorities, thereby undermining essential public health objectives.

¹⁴⁸⁵ *ibid.*

¹⁴⁸⁶ *ibid.*

¹⁴⁸⁷ *ibid.*

¹⁴⁸⁸ *ibid.*

¹⁴⁸⁹ Clapp and Scrinis, ‘Big Food, Nutritionism, and Corporate Power’ (n 1195).

¹⁴⁹⁰ Freeman, ‘Private Parties, Public Functions and the New Administrative Law’ (n 1479).

For example, in Switzerland, with the current Declaration of Milan the soft drink Fanta in Switzerland still contains more than twice the amount of sugar as its counterpart in the UK.¹⁴⁹¹ This difference highlights how relying on voluntary reformulation leaves significant room for industry influence, allowing products to retain high sugar content and directly conflicting with public health objectives. From a normative perspective, such collaborations fail to meet their stated goals of promoting public health and preventing NCDs. Instead, they often work counter to these aims by prioritizing corporate interests over public health imperatives. This stands in contrast to PPPs in other sectors, such as administrative law or infrastructure development, where private involvement, under clear regulatory oversight, can enhance efficiency and deliver tangible public benefits.

3 Spheres Transgression

Theory of justice and complex equality

The theory of justice and complex equality from WALZER, which emphasizes the autonomy of distinct spheres, has been explored by SHARON in the context of the digitalization and Googlization of health.¹⁴⁹² This thesis proposes to extend this conceptual framework to the realm of the food industry and its implications for public health, particularly focusing on the phenomenon of sphere transgression.

WALZER's normative ideal consists of two principal elements: the concept of goods that are internal to distinct spheres of distribution and the principle of the separation of these spheres, underscored by the implicit ideal of non-dominance.¹⁴⁹³ He constructs a theory of justice and complex equality rooted in the autonomy of spheres, where various societal goods such as education, welfare, wealth, friendship, and political authority are distributed distinctly.¹⁴⁹⁴ Although inequalities may exist within individual spheres, WALZER argues that a just society prevents advantages in one sphere from granting power in another. For instance, someone elected to political office should not gain superior healthcare or any advantages in other spheres

¹⁴⁹¹ Peter-Spiess, 'Sucres Ajoutés et Santé Publique' (n 1369).

¹⁴⁹² Sharon, 'Blind-Sided by Privacy?' (n 1478).

¹⁴⁹³ Michael Walzer, *Spheres of Justice: A Defence of Pluralism and Equality* (Robertson 1983) p 7-20.

¹⁴⁹⁴ *ibid.*

because these conversions and transgressions between spheres would constitute a form of tyranny.¹⁴⁹⁵

According to WALZER, a “sphere transgression” occurs when a “dominant good” within one sphere permits the command of goods in other spheres. He defines “dominant good” as “if the individuals who have it because they have it, can command a wide range of other goods”.¹⁴⁹⁶ For example, money granting access to political influence is a form of such transgression. WALZER argues that each sphere of society should largely operate independently, with justice hinging on safeguarding this independence. WALZER’s framework emphasizes the risks of allowing influence from one societal sphere, such as the market, to penetrate another, like public health and politics, potentially eroding each sphere’s distinct values and obligations.

Public Health

First, it is worth highlighting his observation concerning public health. In his analysis of public health, WALZER uses the example of ensuring that urban populations have access to uncontaminated milk.¹⁴⁹⁷ This example illustrates the necessity for enterprises to be subjected to inspections, regulations, and extensive public oversight to prevent the distribution of contaminated food. WALZER posits that there is an inherent conflict between enterprises, which prioritize their own interests, and public activities focused on control, regulation, and enforcement.¹⁴⁹⁸ He underscores that while enterprises like those in the dairy industry advocate for their own interests, these interests often clash with public activities that are of significant value to society, even if they do not serve all individuals equally.¹⁴⁹⁹

This example can be extended to the case of corporations that produce ultra-processed foods. These corporations clearly act in their own self-interest when they promote and sell unhealthy products, and naturally, they resist regulatory measures such as taxation or marketing restrictions on their products. On the opposing side is public health, which serves as a collective good for society. Thus, there is a fundamental conflict between corporate interests and collective values such as health and food.

¹⁴⁹⁵ *ibid.*

¹⁴⁹⁶ *ibid.*, 10.

¹⁴⁹⁷ *ibid.*, 81.

¹⁴⁹⁸ *ibid.*

¹⁴⁹⁹ *ibid.*

Finally, it is important to note WALZER's observation that the dairy industry historically denied the connection between contaminated milk and tuberculosis.¹⁵⁰⁰ However, once the link was established, arguing against the need for milk inspections became increasingly difficult. A similar situation occurred with the tobacco industry, which long denied the adverse health effects of tobacco until the link between tobacco use and cancer was irrefutably established, leading to stricter regulations. Despite the well-established links between unhealthy food consumption and the rise in obesity, diabetes, and related non-communicable diseases, these food corporations continue to operate with minimal regulation. This situation raises significant questions about the adequacy of current regulatory frameworks in addressing the public health risks posed by these products and, in particular, the adoption of PPPs for NCD prevention as an "innovative regulatory approach".

Googlization of health

Regarding the idea of Googlization of health, SHARON identifies an area of technological production in which digital goods are distributed as a sphere.¹⁵⁰¹ Big tech companies have technical expertise in terms of data collection, data analytics, and infrastructure development, which gives them an advantage in the sphere of digital goods. The issue is when their technical expertise extends beyond its original scope to encompass expertise in health and medicine.¹⁵⁰² This transition effectively legitimizes their involvement in initiating research projects, which may, in turn, lead to a preferential focus on specific areas of research while potentially neglecting those deemed less profitable. In addition, she identifies that this conversion of tech expertise into an advantage in the health and medical sphere becomes an advantage in the sphere of politics.¹⁵⁰³ Finally, she underscores that when public health efforts rely heavily on corporate actors to deliver essential health-related goods, it creates a dependency that compromises policy integrity and limits the ability of governments to act independently for the public's welfare.¹⁵⁰⁴ SHARON and colleagues explore the undue influence of "Big Tech" in new societal sectors and how these sectors may be transformed in line with those companies' values and interests, which might counter public values and interests.¹⁵⁰⁵ Due to the vast power of Big Food and Big Soda

¹⁵⁰⁰ *ibid.*

¹⁵⁰¹ Sharon, 'Blind-Sided by Privacy?' (n 1478).

¹⁵⁰² *ibid.*

¹⁵⁰³ *ibid.*

¹⁵⁰⁴ *ibid.*

¹⁵⁰⁵ Marthe Stevens, Steven R Kraaijeveld and Tamar Sharon, 'Sphere Transgressions: Reflecting on the Risks of Big Tech Expansionism' (2024) 27 *Information Communication & Society* 1.

and their undue influence in transforming the public health policy scenario in line with their values and interests, it is worthwhile to apply this analytical lens to PPPs for NCD prevention.

From market advantage to regulatory influence

This part proposes to extend this conceptual framework to the domain of PPPs for NCD prevention. It examines how multinational food corporations' commercial expertise and resources (an advantage in their own sphere) have been strategically converted into regulatory power within the spheres of health and politics. This conversion of spheres has blurred normative boundaries, transforming public health governance into a "non-regulated" space that increasingly prioritizes corporate over public interests. In doing so, it challenges foundational elements in which PPPs are used as a mechanism to avoid or delay stricter regulation.

In the framework of WALZER's idea of "spheres of justice", we might consider the domain of the multinational food and sweetened beverage industries under the market sphere. In this sphere, ultra-processed food industries have expertise in creating and distributing ultra-processed (unhealthy) products to maximize profit.

Their expertise in producing unhealthy products (an advantage within its own sphere, where it is legitimate and legal) becomes a "dominant good" and translates into an advantage in the public health sphere, as they have the know-how for reformulating their products. For instance, one of the justifications for establishing collaborations with the ultra-processed food and sweetened beverage industries is their expertise (on their unhealthy products) to make it easier to meet reformulation efforts. This expertise translates into an advantage in the political sphere, particularly in shaping policies intended to address the NCD crisis. Such dynamics result in a transgression into the public health and political spheres, where priorities should be focused on protecting and promoting population health, remaining free from commercial influence.

This "spheres transgression" resulted in a regulatory gray zone towards multinational food corporations' practices, creating a threat to the collective aim of public health. This encroachment on regulatory power challenges the traditional separation of public and private roles, posing risks to democratic accountability and the integrity of public health policies. Furthermore, private entities operate outside traditional oversight mechanisms typically applied to public agencies. Thus, the concentration of power that results from sphere transgression not only jeopardizes public health objectives but also threatens democratic values by weakening the State's authority in historically public domains.

SHARON identifies that sphere will inevitably overlap at times, but calls for the need to establish clear conditions for the migration of influence between spheres.¹⁵⁰⁶ Building on this, it is essential to ensure that when expertise or resources move from one sphere to another, such as from the economic to the political or public health sphere, they do so in ways that preserve the integrity and objectives of the receiving sphere. This reinforces the importance of establishing clear boundaries around influence to prevent commercial interests from undermining public health priorities. Additionally, the author highlights the application of principles of transparency and accountability, which are critical in maintaining the independence of each sphere and ensuring that public health decisions are made with the welfare of the population, not industry interests.¹⁵⁰⁷

In conclusion, in this context, PPPs for NCD prevention are used as a regulation avoidance mechanism, prioritizing corporate interests over public health objectives. And as a consequence, this dynamic defies its own normative purpose: promoting public health and NCD prevention.

III Conflict of interest

One of the biggest tensions in public-private partnerships with the ultra-processed food and sweetened beverage industries is the conflict of interest between the public health goals of the partnership and the commercial interests of the “risk-creating industries”. On one side, the food industry has a vested interest in maximizing profits through their unhealthy products, which does not align with the public health goal to prevent NCDs by reducing consumption of unhealthy foods.

1 Definition

The concept of conflict of interest has its origins in fiduciary law and has primarily been defined as a situation where “whenever activities or relationships compromise the loyalty or independent judgment of an individual who is obligated to serve a party or perform certain roles. Multiple interests often pull people in different directions, but only when they compromise, fulfilling obligations, is there a conflict of interest”.¹⁵⁰⁸ It is important to highlight

¹⁵⁰⁶ Sharon, ‘Blind-Sided by Privacy?’ (n 1478).

¹⁵⁰⁷ These principles will be explored in Part 4.

¹⁵⁰⁸ Marc A Rodwin, ‘Attempts to Redefine Conflicts of Interest’ (2017) 25 *Accountability in Research* 67.

that legally, there is the idea of an obligation to be fulfilled. In the case of PPPs to NCD Prevention, there is a government obligation to fulfil the right to health and the right to adequate food. On the other hand, the same obligation does not apply to corporations (in theory).¹⁵⁰⁹ Importantly, one core characteristic of the definition of COI is that “Conflicts of interest can influence action, but they are not acts, and do not constitute a breach of duty.”¹⁵¹⁰

In essence, an interest itself can be seen as a driving factor in human behavior.¹⁵¹¹ Moreover, conflicts of interest have important characteristics. For instance, it permeates various aspects of life within complex societies, emerging from diverse interacting interests, many of which can occur without the involved party being consciously aware.¹⁵¹²

THOMPSON defines conflict of interest as a “set of conditions in which professional judgement concerning a primary interest (patient’s welfare or the validity of research) tends to be unduly influenced by a secondary interest (such as financial gain)”.¹⁵¹³ The so-called Thompson-IOM definition has been extensively used in the medical field. It is considered a broad definition that can be applied equally to individual and institutional conflicts of interest.¹⁵¹⁴ It has been pointed out that the Thompson-IOM definition is different from the legal definition of COI because it focuses on bias, referring to conflicts between primary and secondary interests rather than conflicts between obligations and interests.¹⁵¹⁵ As a result, this definition is considered less precise or useful as a policy instrument than the traditional legal definition.¹⁵¹⁶ Nevertheless, as explored next, this has been the definition used by WHO in the context of NCDs.

A crucial aspect of conflict of interest is the difference between actual and perceived conflict of interest. Actual COI is “when a secondary interest simply has the potential to unduly influence official judgment or action.”¹⁵¹⁷ It occurs through monetary or material benefits. For instance, a company gives something of value (speaking fees, a gift, hospitality, paid travel) to

¹⁵⁰⁹ Part 4, Chapter 12, I, 4.1 and 4.2.

¹⁵¹⁰ Rodwin, ‘Attempts to Redefine Conflicts of Interest’ (n 1508).

¹⁵¹¹ Bartlett and Garde, ‘Chapter 13: the EU Platform and the EU Forum’ (n 703) 300.

¹⁵¹² *ibid.*

¹⁵¹³ Dennis F Thompson, ‘Understanding Financial Conflicts of Interest’ (1993) 329 *New England Journal of Medicine* 573.

¹⁵¹⁴ World Health Organization, ‘Addressing and Managing Conflicts of Interest in the Planning and Delivery of Nutrition Programmes at Country Level: Report of a Technical Consultation Convened in Geneva, Switzerland, on 8–9 October 2015’ (WHO 2016).

¹⁵¹⁵ Rodwin, ‘Attempts to Redefine Conflicts of Interest’ (n 1508).

¹⁵¹⁶ *ibid.*

¹⁵¹⁷ WHO, ‘Addressing and Managing Conflicts of Interest’ (n 1514).

an official.¹⁵¹⁸ Thus, the official's own monetary or material benefits the capacity to influence the objectivity of their judgement.¹⁵¹⁹

On the other hand, a perceived conflict of interest occurs when there is a reasonable perception of such conflict, even if it may not actually exist.¹⁵²⁰ It happens through non-monetary or non-material influences it exerts on the official or agency. An illustrative scenario of a perceived conflict of interest arises when a multinational food manufacturer pressures the government to adopt a specific data system for compiling information about child nutrition by threatening to withdraw its investments in the country if the government does not comply.¹⁵²¹ This context introduces the relevant term "undue influence," which means improper influence.¹⁵²²

It has been elucidated that private businesses have different avenues through which they can interact with governmental bodies, encompassing legitimate interventions such as lobbying, the presentation of briefs, and involvement in multi-member stakeholder platforms. It has been argued that as long as those interventions are made on the merits and are transparent, they do not pose a conflict of interest.¹⁵²³ This differs from "undue influence" which occurs when monetary connections that an official or agency has with a vested interest, will generally be a private for-profit business (actual COI) or situation where non-monetary relationships between an official and a private interest, such as relationships of favoritism, coercion and unequal power (perceived COI).¹⁵²⁴

Moreover, a study defining which situations may create a higher risk for an actual COI identified three situations: where the private interest's capacity to benefit the public decision-maker is significant; the public decision-maker's capacity to affect the private interest is significant and when the private interest's stake in the outcome is critical to its success or survival.¹⁵²⁵ Concerning higher risk perceived COI, the study underscores the following situations: a private interest is sufficiently powerful within the country's economy that the official/agency might accede to its wishes even if they do not believe that doing so is in the public interest, a private interest is sufficiently powerful within the country's public decision making apparatus that it begins to occupy not simply a private but also a quasi-public role, an

¹⁵¹⁸ *ibid.*

¹⁵¹⁹ *ibid.*

¹⁵²⁰ *ibid.*

¹⁵²¹ *ibid.*

¹⁵²² *ibid.*

¹⁵²³ *ibid.*

¹⁵²⁴ *ibid.*

¹⁵²⁵ *ibid.*

official/agency's endorsement of a private company or its products is sufficiently significant that public trust and credibility are at stake, and an official/agency's support for a private company amounts to undue preference or favoritism, an undue advantage in the private market place.¹⁵²⁶

This raises the question of how to manage existing, potential, or perceived conflicts of interest in global public health, particularly within the context of non-communicable diseases, public health promotion, public-private partnerships, and the food industry.

2 Conflict of interest and private actors within the WHO framework

The Framework of Engagement with Non-State Actors (FENSA) adopted in 2016 by the WHO sets the principles for engagement with private actors. It determines that non-state actors are nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions. The private sector comprehends commercial enterprises. In other words, businesses that are intended to make a profit.¹⁵²⁷

The core elements of this Framework's guiding principles are a clear benefit to public health and effective management to avoid conflicts of interest and other forms of risk to the WHO.¹⁵²⁸

According to FENSA, conflict of interest occurs when there is potential for a secondary interest to excessively influence, or where it may be reasonably perceived to excessively influence, either the independence or objectivity of professional judgement or actions regarding a primary interest (WHO's work).¹⁵²⁹ It highlights that to exist a conflict of interest does not implicitly mean that improper action has occurred, "but rather the risk of such improper action occurring".¹⁵³⁰ In addition, conflicts of interest are not exclusively financial but can take other forms as well.¹⁵³¹

Moreover, it differentiates individual from institutional COI. Institutional conflict of interest is described as "a situation where WHO's primary interest (...) may be unduly influenced by the conflicting interest of a non-State actor in a way that affects or may reasonably be perceived to

¹⁵²⁶ *ibid.*

¹⁵²⁷ World Health Organization, 'Framework of Engagement with Non-State Actors' (*WHO* 2016) <<https://www.who.int/about/collaboration/non-state-actors>> art. 10, accessed 5 June 2025.

¹⁵²⁸ *ibid.*, art 5.

¹⁵²⁹ *ibid.*, art 22.

¹⁵³⁰ *ibid.*

¹⁵³¹ *ibid.*

affect the independence and objectivity of WHO's work."¹⁵³² It underscores that WHO is often faced with a combination of converging and conflicting interests when engaging with non-state actors due to the multiple interests of institutions.¹⁵³³

FENSA also emphasizes "where particular caution should be exercised," stressing that WHO must be especially careful when interacting with private sector entities whose activities negatively affect human health, making special reference to related noncommunicable diseases and their determinants.¹⁵³⁴ Moreover, it explicitly states that WHO does not engage with the tobacco or arms industries.¹⁵³⁵ Nevertheless, it is silent about multinational food corporations.

Finally, to establish an engagement with a non-state actor, the WHO conducts due diligence and risk assessment.¹⁵³⁶ Due diligence includes reviewing the information provided by the non-state actor, searching for information about the entity concerned from other sources, and analyzing all the information obtained.¹⁵³⁷ Whereas risk management concerns the process leading to a management decision, in this stage, the Secretariat decides explicitly and justifiably on entry into engagement with measures to mitigate risks.¹⁵³⁸

Interestingly, it determines that the highest potential risk of institutional conflicts of interest could be in situations where "the interest of non-State actors, in particular economic, commercial or financial, conflict with WHO's public health policies, constitutional mandate and interests, in particular, the Organization's independence and impartiality in setting policies, norms and standards".¹⁵³⁹ The interference of multinational food companies in WHO public health policies on NCD prevention has been highly demonstrated and discussed.¹⁵⁴⁰ Nevertheless, the food industry is left outside the scope of FENSA.

3 Conflict of interest in other areas

¹⁵³² *ibid*, art 24.

¹⁵³³ *ibid*, art 24.

¹⁵³⁴ *ibid*, art 45.

¹⁵³⁵ *ibid*, art 44.

¹⁵³⁶ *ibid*, art 29.

¹⁵³⁷ *ibid*, art 30.

¹⁵³⁸ *ibid*, art 34.

¹⁵³⁹ *ibid*, art 26.

¹⁵⁴⁰ Kathrin Lauber, Harry Rutter and Anna B Gilmore, 'Big Food and the World Health Organization: A Qualitative Study of Industry Attempts to Influence Global-Level Non-Communicable Disease Policy' (2021) 6 *BMJ Global Health*; Norum, 'World Health Organization's Global Strategy on Diet, Physical Activity and Health' (n 930).

Breast-milk substitutes

The issue of conflict of interest has been recognized concerning the tobacco industry through Art. 5.3 FCTC.¹⁵⁴¹ In addition, the topic of conflict of interest has been highly discussed in the scope of breast-milk substitutes. The International Code of Marketing of Breast-milk Substitutes, adopted by the World Health Assembly in 1981, does not explicitly mention the wording “conflict of interest”, nevertheless, it contains several provisions that are related to the issue.

The code defines “manufacturer” as a corporation or other entity in the public or private sector engaged in the business or function of manufacturing a product within the scope of this code.¹⁵⁴² For instance, Art. 5.4 states, “manufacturers and distributors should not distribute to pregnant women or mothers of infants and young children any gifts or articles or utensils which may promote the use of breast-milk substitutes.” In addition, Art. 6.2 prohibits the health care system from being used to promote infant formula.¹⁵⁴³ Finally, Art. 7.3 states that “no financial or material inducements to promote breast-milk substitute products should be offered by manufacturers or distributors to health workers or members of their families”.¹⁵⁴⁴

These articles demonstrate the idea of preventing commercial interests from influencing the advice and support that health professionals provide to mothers regarding infant feeding. By restricting the interactions between the breast-milk substitute industry and health care providers, the Code aims to safeguard public health policies and ensure that infant feeding decisions are based on children’s best interests and public health, rather than commercial gain.

After the adoption of the International Code of Marketing of Breast-milk Substitutes, a few World Health Assembly Resolutions have been adopted alluding to the issue of conflict of interest. First, in 1996, Resolution WHA49.15 calls on Member States to ensure that the Code monitoring is carried out independently, transparently, and free from commercial interest.¹⁵⁴⁵ And it urges member states “to ensure that the financial support for professionals working in infant and young child health does not create conflicts of interest, especially with regard to the WHO/UNICEF Baby Friendly Hospital Initiative”.¹⁵⁴⁶ In 2005, Resolution WHA58.32 asked

¹⁵⁴¹ This issue was already explored in Chapter 5, IV Binding instruments. WHO Framework Convention on Tobacco Control (n 31).

¹⁵⁴² World Health Organization, *International Code of Marketing of Breast-milk Substitutes* (1981).

¹⁵⁴³ *ibid.*

¹⁵⁴⁴ *ibid.*

¹⁵⁴⁵ World Health Organization, *Forty-ninth World Health Assembly WHA49/1996/REC/1* (Geneva, 20–25 May 1996).

¹⁵⁴⁶ *ibid.*

Member States to “ensure that financial support and other incentives for programmers and health professionals working in infant and young child health do not create conflicts of interest.”¹⁵⁴⁷

In 2008, Resolution WHA61.20 urged Member States to “scale up efforts to monitor and enforce national measures and to avoid conflicts of interest”.¹⁵⁴⁸ In 2012, Resolution 65.6 on maternal, infant and young child nutrition, requested the Director General of the WHO “to develop risk assessment, disclosure and management tools to safeguard against possible conflicts of interest in policy development and implementation of nutrition programmes consistent with WHO’s overall policy and practice”.¹⁵⁴⁹

In May 2016, the WHA welcomed the WHO Guidance on ending the inappropriate promotion of foods for infants and young children, which includes a specific recommendation on “avoidance of conflict of interest”.¹⁵⁵⁰ It affirms that companies marketing foods for infants and young children should not create COI in health facilities or throughout health systems, providing a list of examples of activities or strategies that constitute COI.¹⁵⁵¹

In 2003, the WHO and UNICEF developed the Global Strategy on Infant and Young Child Feeding to guide policies and actions aimed at improving infant and young child feeding practices worldwide. The strategy underscores the shared responsibility among governments, international organizations, and other concerned parties to ensure the fulfillment of the right of children to the highest attainable standard of health and the right of women to full and unbiased information, and adequate health care and nutrition.¹⁵⁵² Furthermore, the strategy emphasizes that “all partners should work together to achieve fully this strategy’s aim and objectives, including by forming fully transparent innovative alliances and partnerships consistent with accepted principles for avoiding conflict of interest.”¹⁵⁵³

Focusing on the children’s interests, Resolution WHA 63.14 in Marketing of Food and non-alcoholic beverages to Children urges Member States “to cooperate with civil society and with

¹⁵⁴⁷ IBFAN-ICDC, *Code Essentials 1: Annotated International Code of Marketing of Breastmilk Substitutes and Subsequent WHA Resolutions* (Penang, Malaysia: IBFAN S/B, 2018).

¹⁵⁴⁸ *ibid.*

¹⁵⁴⁹ World Health Assembly, *Comprehensive implementation plan on maternal, infant and young child nutrition* WHA 65.6 (26 May 2012).

¹⁵⁵⁰ World Health Organization, *Recommendation 6. Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children: Implementation Manual* (Geneva, 2017).

¹⁵⁵¹ *ibid.*

¹⁵⁵² World Health Organization and United Nations Children’s Fund, *Global Strategy on Infant and Young Child Feeding* (2003) art 35.

¹⁵⁵³ *ibid.*

public and private stakeholders in implementing the set of recommendations on the marketing of foods and non-alcoholic beverages to children in order to reduce the impact of that marketing while ensuring avoidance of potential conflicts of interest”.¹⁵⁵⁴ Nonetheless, the resolution falls short in specifying clear methods or guidelines for effectively managing these conflicts of interest.

In conclusion, while conflicts of interest within the infant formula industry have been acknowledged and scrutinized, they have not led to exclusion from global health collaborations, unlike the tobacco industry.¹⁵⁵⁵ For instance, no specific provision is made on FENSA about the infant formula industry. Despite its significant role in shaping infant nutrition policies, the breast-milk substitute industry remains a stakeholder in various public health initiatives, similar to the ultra-processed food corporations’ role in global health discussions. This alignment highlights a persistent gap in how conflicts of interest are managed across industries that impact public health, raising critical questions about the global health governance.

4 Conflict of interest and NCD prevention

WHO’s definition of conflict of interest

In 2011, ahead of the UN High-Level Meeting on NCDs, concerns were raised about conflicts of interest for corporations that profit from selling foods high in fat, salt, and sugar, key contributors to NCDs.¹⁵⁵⁶ At that time, there was a call for these conflicts to be explicitly acknowledged and addressed.¹⁵⁵⁷

In the context of public health and nutrition, the WHO defines conflict of interest as “where there is potential for a secondary interest (a vested interest in the outcome of Member States’ work in the area of public health nutrition) to unduly influence, or where it may be reasonably perceived to unduly influence, either the independence or objectivity of professional judgement or actions regarding a primary interest (related to Member States’ work in the area of public

¹⁵⁵⁴ World Health Assembly, *Marketing of Food and Non-Alcoholic Beverages to Children*, Sixty-third World Health Assembly, Agenda Item 11.9, WHA 63.14 (21 May 2010).

¹⁵⁵⁵ Baby Milk Action, ‘Update 46 – Page14: WHO and Commercial Influence’ (*Baby Milk Action* 2013) <<https://www.babymilkaction.org/update46page14>> accessed 6 November 2024.

¹⁵⁵⁶ Paul Lincoln and others, ‘Conflicts of Interest and the UN High-Level Meeting on Non-Communicable Diseases’ (2011) 378 *The Lancet*.

¹⁵⁵⁷ *ibid.*

health nutrition).”¹⁵⁵⁸ In addition, it emphasizes that “the existence of conflict of interest in all its forms does not necessarily mean that improper action has occurred, but rather that there is a risk of improper action occurring.”¹⁵⁵⁹

Furthermore, the WHO differentiates between institutional and individual conflicts of interest. Institutional is related to a situation “where a Member State’s primary interest, as reflected in its institutional mandate to protect and promote public health, may be unduly influenced by the conflicting interest of a non-State actor in a way that affects or may reasonably be perceived to affect, the independence and objectivity of the Member State’s work in the area of public health nutrition”. In contrast, individual conflict of interest refers to “a private interest (financial, personal, or other non-governmental interest or commitment)” that might interfere with the “ability to act impartially, discharge their functions or regulate their conduct in the sole interests of public health nutrition.”¹⁵⁶⁰

Legal gaps in global health law

One of the overarching principles of the WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020 is the “management of real, perceived or potential conflicts of interest” which highlights that “public health policies for the prevention and control of NCDs must be protected from undue influence by any form of vested interest. Real, perceived, or potential conflicts of interest must be acknowledged and managed”.¹⁵⁶¹ Nevertheless, it does not go further into how to protect from the conflict of interest.

After the adoption of the WHO Global Action, the WHO Director General at the time stated that “efforts to prevent non-communicable diseases go against the business interests of powerful economic operators [...] In the view of WHO, the formulation of health policies must be protected from distortion by commercial or vested interests”.¹⁵⁶² Although these important

¹⁵⁵⁸ World Health Organization, EB142/23, *Safeguarding against possible conflicts of interest in nutrition programmes: Draft approach for the prevention and management of conflicts of interest in the policy development and implementation of nutrition programmes at country level* (142nd session, 4 December 2017) para 10.

¹⁵⁵⁹ *ibid*, para 10.

¹⁵⁶⁰ *ibid*, para 112.

¹⁵⁶¹ WHO, *Global Action Plan for the Prevention and Control 2013–2020* (n 619) 13.

¹⁵⁶² World Health Organization, ‘WHO Director-General Addresses Health Promotion Conference’ (WHO 2013) <<https://www.who.int/director-general/speeches/detail/who-director-general-addresses-health-promotion-conference>> accessed 4 July 2025.

remarks, efforts by WHO Member States to develop clear principles addressing institutional conflicts of interest concerning the food sector have generally lacked the specificity¹⁵⁶³

The Political Declaration of the Third High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases from 2018 calls on States and the international community to “engage with the private sector, taking into account national health priorities and objectives for its meaningful and effective contribution to the implementation of national responses to non-communicable diseases to reach Sustainable Development Goal target 3.4 on non-communicable diseases, while giving due regard to managing conflicts of interest”.¹⁵⁶⁴ Still, it is not established the terms of engagement with the food industry. As pointed out what “would amount to ‘giving due regard to managing conflicts of interest?’”¹⁵⁶⁵ It is imperative that more explicit rules are established to ensure that real, potential, and perceived conflicts of interest are acknowledged and carefully managed.¹⁵⁶⁶

The WHO draft approach

One attempt to guide states in dealing with conflicts of interest was seen in 2017 when the WHO published a “Draft approach on the prevention and management of conflicts of interest in the policy development and implementation of nutrition programs at the country level”. This draft approach proposes a methodology for Member States to consider in their engagement with individuals and non-state actors for preventing and managing conflicts of interest in the area of nutrition.¹⁵⁶⁷ Central to this approach is its comprehensive consideration of potential risks of conflict involving various actors, with a notable emphasis on commercial interests and evaluating their alignment with nutritional objectives.¹⁵⁶⁸ A recent analysis revealed that the Draft was extensively supported by Member States, many NGOs, and academic institutions, but encountered a lot of criticism from the commercial sector.¹⁵⁶⁹

¹⁵⁶³ Garde, Jeffery and Rign, ‘Implementing the WHO Recommendations Whilst Avoiding Real’ (n 979).

¹⁵⁶⁴ UNGA, ‘Political declaration of the 3rd High-Level Meeting’ (n 68) para 43.

¹⁵⁶⁵ Amandine Garde and Jure Zrilič, ‘International Investment Law and Non-Communicable Diseases Prevention’ (2020) 21 *The Journal of World Investment & Trade* 649.

¹⁵⁶⁶ *ibid.*

¹⁵⁶⁷ WHO, EB142/23 (n 1558) para 5.

¹⁵⁶⁸ Rob Ralston and others, ‘Towards Preventing and Managing Conflict of Interest in Nutrition Policy? An Analysis of Submissions to a Consultation on a Draft WHO Tool’ (2020) 10 *International Journal of Health Policy and Management*.

¹⁵⁶⁹ *ibid.*

The WHO Draft has been described as “a step-change in WHO thinking on large corporations and nutrition policy.” In addition, it has been compared to Art. 5.3 of the FCTC, giving the potential to protect public health from industry interests.¹⁵⁷⁰

The WHO Draft proposes a six-step process through which Member States assess the appropriateness of a proposal for collaboration with an external actor. The first three steps focus on assessing the appropriateness of a proposed collaboration.¹⁵⁷¹ Steps 4-6 of the tool provide a framework for establishing the parameters of the collaboration and establishing appropriate measures to ensure accountability and transparency.

Legal pathways for safeguarding public health

Considerable emphasis has been placed on the importance of COI prevention and management. Prevention has been emphasized as an important area to avoid situations where the private industry will prevail. In terms of COI management, recommendations include the establishment of a legal framework with regulatory monitoring, binding rules, and sanctions.¹⁵⁷² In addition, monitoring and enforcement of policies have been highlighted. For instance, accountability mechanisms should be introduced to monitor industry compliance and ensure penalties and disincentives for non-compliance.¹⁵⁷³

Conflict of interest is inherent in the PPPs for NCD prevention with food corporations. The ultra-processed food and sweetened beverages industries are interested in increasing their profits through their unhealthy products. Nevertheless, it is imperative to recognize that this interest (considered a second interest) must not unduly influence the primary interest of States, namely, the public health interest. States bear the fundamental obligation to safeguard the right to health and adequate food. Consequently, any collaborations established with industries involved in the production of ultra-processed foods and sweetened beverages must be subject to meticulous scrutiny. In particular, States must exercise robust oversight to prevent undue influence by private actors, especially in the setting of the reformulation targets. Thus, to

¹⁵⁷⁰ Gary Jonas Fooks and Charlotte Godziewski, ‘The World Health Organization, Corporate Power, and the Prevention and Management of Conflicts of Interest in Nutrition Policy Comment on “Towards Preventing and Managing Conflict of Interest in Nutrition Policy? An Analysis of Submissions to a Consultation on a Draft WHO Tool”’ (2020) 11 International Journal of Health Policy and Management.

¹⁵⁷¹ Ralston and others, ‘Towards Preventing and Managing Conflict’ (n 1568).

¹⁵⁷² WHO, ‘Addressing and Managing Conflicts of Interest’ (n 1514).

¹⁵⁷³ *ibid.*

effectively address the issue of conflicts of interest within these partnerships, two paramount guiding principles emerge: transparency and accountability.¹⁵⁷⁴

IV Lobbying and PPPs for NCD prevention as a regulation avoidance mechanism

1 Definition

While lobbying is not a novel phenomenon, its strategic deployment in the context of PPPs for NCD prevention deserves a detailed analysis. In this domain, lobbying often operates not merely as a means to influence the specifics of regulation, but to reshape the regulatory approach itself. Industry actors have actively lobbied in favor of PPPs as an alternative to command-and-control approaches in the context of NCD prevention, ultimately using them as an avoidance mechanism to regulation.

Various actors engage in lobbying activities to influence and shape public decision-making, often competing or collaborating in the process. These actors represent a broad spectrum of interests, including economic (corporations and business associations), professional (trade unions and professional societies), and civil society (environmental or religious organizations).¹⁵⁷⁵

Lobbying can be classified in different ways and is often considered a key component of nonmarket strategies. In this context, instrumental lobbying is defined as “a concerted pattern of actions taken in the nonmarket environment to create value by improving its overall performance”.¹⁵⁷⁶ The aim of instrumental lobbying is to lobby “for a more favorable hearing in the ears of politicians”.¹⁵⁷⁷ Companies lobby intending to maximize profit and preserve the status quo. In sum, lobbying may be defined as “activities undertaken with the aim of influencing legislative/regulatory processes and outcomes.”¹⁵⁷⁸

¹⁵⁷⁴ These principles will be detailed in the last part of this thesis Part 4, Chapter 12.

¹⁵⁷⁵ Suzanne Mulcahy, ‘Lobbying in Europe: Hidden Influence, Privileged Access’ (Transparency International 2015).

¹⁵⁷⁶ Irina Lock and Peter Seele, ‘Deliberative Lobbying? Toward a Noncontradiction of Corporate Political Activities and Corporate Social Responsibility?’ (2016) 25 *Journal of Management Inquiry* 415.

¹⁵⁷⁷ *ibid.*

¹⁵⁷⁸ *ibid.*

Thus, lobbying seeks to align legislative outcomes with corporate interests and, in many cases, is considered a legitimate aspect of the democratic process.¹⁵⁷⁹ However, it often results in policy decisions that prioritize the short-term gains of a few corporate actors over the broader public health interest.¹⁵⁸⁰ While industry lobbying has been extensively studied in the context of tobacco control, a growing body of evidence indicates that the food and alcohol industries employ similar tactics to influence policy.¹⁵⁸¹

Lobbying has also been described as “part of a company’s information-seeking strategy, which aims to affect public policy by providing policymakers specific information about preferences for policy or policy positions and may involve providing information on the costs and benefits of different issue outcomes.”¹⁵⁸²

NESTLE vastly explored lobbying within the American context. She defines lobbying as “any legal attempt by individuals or groups to influence government policy or action”.¹⁵⁸³ The author highlights that the definition explicitly excludes bribery.¹⁵⁸⁴ Furthermore, NESTLE identifies three fundamental components of lobbying: the promotion of the views of special-interest groups, the effort to influence governmental laws, regulations, or policies affecting these groups, and communication with government officials or their representatives regarding pertinent rules or policies.¹⁵⁸⁵ Although lobbying is regulated in the United States, the author notes that the legislation is often ambiguous, allowing companies to exploit numerous loopholes. Additionally, the enforcement and compliance with these regulations are generally low, rendering them largely ineffective.¹⁵⁸⁶ Finally, she enumerates various lobbying methods, including offering expertise, arranging campaign contributions, and organizing public demonstrations, among others.¹⁵⁸⁷

A recent study has shown that in the US, the UPF industry spent the most (\$1.15 billion) on lobbying compared to the tobacco, alcohol, and gambling industries.¹⁵⁸⁸ Moreover, the

¹⁵⁷⁹ Garde and others, ‘Lobbying, Transparency and Trust’ (n 726).

¹⁵⁸⁰ *ibid.*

¹⁵⁸¹ Brownell and Warner, ‘The Perils of Ignoring History’ (n 30).

¹⁵⁸² Amy J Hillman, Gerald D Keim and Douglas Schuler, ‘Corporate Political Activity: A Review and Research Agenda’ (2004) 30 *Journal of Management* 837.

¹⁵⁸³ Marion Nestle, *Food Politics: How the Food Industry Influences Nutrition and Health* (University of California Press 2007) 95.

¹⁵⁸⁴ *ibid.*

¹⁵⁸⁵ *ibid.*

¹⁵⁸⁶ Nestle, *Soda Politics: Taking on Big Soda* (n 784) 316.

¹⁵⁸⁷ Nestle, *Food Politics: How the Food Industry Influences Nutrition and Health* (n 1583) 95.

¹⁵⁸⁸ Holly Chung, Katherine Cullerton and Jennifer Lacy-Nichols, ‘Mapping the Lobbying Footprint of Harmful Industries: 23 Years of Data from OpenSecrets’ (2024) 102 *The Milbank Quarterly*.

expenses are related to a year in which regulation is discussed, such as the tax on sugary drinks in 2009.¹⁵⁸⁹

In the European context, lobbying practices have been described to include delaying the adoption of legislation, questioning scientific evidence that links the consumption of unhealthy products to adverse health effects, creating industry groups to promote corporate interests, relocating the causes of disease to alternative risk factors, focusing on individual responsibility and suggesting less effective alternative measures.¹⁵⁹⁰

2 Corporate political activity

Instrumental lobbying has been identified as a form of corporate political activity.¹⁵⁹¹ Vastly explored in the area of tobacco and alcohol, corporate political activity is defined as “corporate attempts to shape government policy in ways favorable to the firm”.¹⁵⁹² It has been used to analyze from a lens to interpret industry efforts to oppose regulation.¹⁵⁹³

The corporate political activity of the food industry has been identified under six different strategies: information and messaging; financial incentives; constituency building; legal strategies; policy substitution; and opposition fragmentation and destabilization.¹⁵⁹⁴ The information strategy comprehends practices through which the industry disseminates information that is beneficial to its activities to influence public health policies and outcomes in a way that would favor corporations. For instance, lobbying policymakers, stressing the industry’s economic importance, promoting deregulation, framing the debate on diet- and public health-related issues (focusing on individual responsibility), and shaping the evidence base on diet- and public health-related issues.¹⁵⁹⁵

Under the financial incentives strategy, the industry provides funds, gifts, and other incentives to politicians, political parties, and other decision-makers.¹⁵⁹⁶ The constituency-building strategy aims to gain the favor of public opinion as well as other stakeholders, such as the media

¹⁵⁸⁹ See the examples explored in Part 3, Chapter 11, IV, 3.

¹⁵⁹⁰ Tselengidis and Östergren, ‘Lobbying against Sugar Taxation in the European Union’ (n 705).

¹⁵⁹¹ Lock and Seele, ‘Deliberative Lobbying?’ (n 1576).

¹⁵⁹² Hillman, Keim and Schuler, ‘Corporate Political Activity’ (n 1582).

¹⁵⁹³ Lauber, Rutter and Gilmore, ‘Big Food and the World Health Organization’ (n 1540).

¹⁵⁹⁴ Melissa Mialon, Boyd Swinburn and Garry Sacks, ‘A Proposed Approach to Systematically Identify and Monitor the Corporate Political Activity of the Food Industry with Respect to Public Health Using Publicly Available Information’ (2015) 16 *Obesity Reviews* 519.

¹⁵⁹⁵ *ibid.*

¹⁵⁹⁶ *ibid.*

and the public health community, including practices like the establishment of public-private partnerships.¹⁵⁹⁷ The legal strategies comprehend the alternative solutions proposed by the industry, such as voluntary initiatives or self-regulation, to avoid regulation. In addition, the food industry also sues its opponents and challenges public policies in courts.¹⁵⁹⁸

The fragmentation and destabilization strategy refers to the practices employed by the industry to prevent and counteract criticism of a company's products or practices, such as criticizing public health advocates and infiltrating and distracting public health advocates, groups, and organizations.¹⁵⁹⁹

3 Examples

Opposing regulation

Opposing regulation is one of the main strategies of the food and sweetened beverage industries' lobbying. For example, in 2009, the introduction of an excise tax on sugary drinks in the United States was abandoned due to the beverage industry's extensive lobbying efforts.¹⁶⁰⁰ Here, the primary strategy used was research questioning the link between soda and obesity.¹⁶⁰¹

Moreover, the American Beverage Association has intensively lobbied against government actions that would increase the costs of soda production and marketing or discourage the consumption of its products. This includes lobbying against measures such as nutrition labelling, sugar packaging standards, and restrictions on television advertising aimed at children.¹⁶⁰²

This is not an isolated example from the US. The lobbying from Big Food and Big Soda against the regulation of their products is seen worldwide. For instance, recently, in Switzerland, the

¹⁵⁹⁷ *ibid.*

¹⁵⁹⁸ *ibid.*

¹⁵⁹⁹ *ibid.*

¹⁶⁰⁰ Lock and Seele, 'Deliberative Lobbying?' (n 1576).

¹⁶⁰¹ *ibid.*

¹⁶⁰² Nestle, *Soda Politics: Taking on Big Soda* (n 784) 316.

House of Representatives rejected two cantonal public-health initiatives aiming to regulate sugar in food and drinks due to the powerful sugar-industry lobby.¹⁶⁰³

In Europe, a significant instance of food industry lobbying has been directed against the implementation of Nutri-Score.¹⁶⁰⁴ For instance, FoodDrinkEurope is a prominent lobbying group representing major brands such as Kinder, Nutella, and Ferrero Rocher (Ferrero group); Côte d'Or, LU, Milka, Oreo, Toblerone, and TUC (Mondelez group); as well as Minute Maid, Fanta, Sprite, and Coca-Cola, and has actively lobbied against Nutri-Score.¹⁶⁰⁵

In 2010, the food industry in Europe invested approximately €1 billion in a successful lobbying campaign to persuade the European Parliament to reject a proposed traffic-light food labeling scheme.¹⁶⁰⁶ This legislative proposal aimed to mandate the inclusion of nutritional information on food packages. Key opponents of this initiative included the industry association Confederation of the Food and Drink Industries of the EU and the industry-sponsored research institute, European Food Information Council. The industry advocated for a voluntary system known as the Guideline Daily Amount, which displays the calorie content per portion of packaged food.¹⁶⁰⁷ The criticism against this system is that it misleads consumers since the size of the portion can be chosen freely by the company, there is no color coding of the traffic light, and the labeling is voluntary.¹⁶⁰⁸ During the consultation process among EU member states, the food industry employed a strategy of co-opting policymakers to vote against the regulation.¹⁶⁰⁹

In addition, Nutri-Score has faced significant opposition from countries such as Italy, which engaged in state lobbying against it. The Ministry of Agriculture, Food and Forestry Policies aligned with national food and agriculture trade associations, arguing that Nutri-Score would unjustly penalize products from the Mediterranean diet and traditional Italian products.¹⁶¹⁰

¹⁶⁰³ Philippe Boeglin, 'En Plein Débat Sur Le Sucre, Des Élus Fédéraux Invités Pour Écouter Coca-Cola Plaider Sa Cause' (*Le Temps* 2023) <<https://www.letemps.ch/suisse/berne/plein-debat-sucre-elus-federaux-invites-ecouter-cocacola-plaider-cause>> accessed 4 July 2025.

¹⁶⁰⁴ Hercberg, *Mange et Tais-Toi* (n 1422).

¹⁶⁰⁵ Food Watch, 'Strategies Used by the Agro-Industrial Lobby against a Mandatory Nutri-Score' (*Food Watch* 2024) <<https://www.foodwatch.org/en/strategies-used-by-the-agro-industrial-lobby-against-a-mandatory-nutri-score>> accessed 5 August 2024.

¹⁶⁰⁶ Lock and Seele, 'Deliberative Lobbying?' (n 1576).

¹⁶⁰⁷ *ibid.*

¹⁶⁰⁸ *ibid.*

¹⁶⁰⁹ *ibid.*

¹⁶¹⁰ Morgane Fialon, Lydiane Nabec and Chantal Julia, 'Legitimacy of Front-of-Pack Nutrition Labels: Controversy over the Deployment of the Nutri-Score in Italy' (2022) 11 *International Journal of Health Policy and Management*.

One of the strategies identified in the food industry’s lobbying against Nutri-Score has been the production and dissemination of biased research, designed to distort the evidence base in favor of industry interests and to cast doubt on the health risks linked to its products and practices.¹⁶¹¹

Lobbying for PPPs

At the international level, during the consultative process for the Political Declaration of the Third High-level Meeting on the prevention and control of NCDs in 2018, the food and beverage industries aggressively opposed SSB taxes. They lobbied in favor of a multi-stakeholder approach, which is highlighted in the final text of the declaration.¹⁶¹²

Beyond traditional lobbying to blocking or weakening legislation that may negatively affect their commercial interests, the food and beverage industries have increasingly promoted public-private partnerships as a strategic alternative regulatory approach. For instance, Indra Nooyi, PepsiCo’s former CEO, declared that the world’s problems couldn’t be solved exclusively by the government, affirming that the only way is through public-private partnerships between the government and companies.¹⁶¹³ By positioning themselves as public health stakeholders, they lobby for the adoption of voluntary collaborations. In this light, industries lobby in favor of PPPs for NCD prevention as a mechanism to avoid stricter, command-and-control regulation.

CONCLUDING REMARKS ON PART 3

Influenced by new public management and neoliberalism beliefs, public-private partnerships emerged as an alternative legal tool that has been widely adopted across various sectors. In administrative law, they are often employed to deliver public services, while in global health, they have facilitated complex multilateral collaborations, for example, to develop vaccines or improve access to essential medicines. A new form of PPP is the voluntary collaborations with the private sector for NCD prevention.

¹⁶¹¹ Amandine Garde and others, ‘Unpacking Front-of-Pack Nutrition Labelling Research: When the Food Industry Produces “Science” as Part of Its Lobbying Strategies’ (2024) 15 *World Nutrition* 63.

¹⁶¹² Mao Suzuki, Douglas Webb and Roy Small, ‘Competing Frames in Global Health Governance: An Analysis of Stakeholder Influence on the Political Declaration on Non-Communicable Diseases’ (2021) 11 *International Journal of Health Policy and Management*.

¹⁶¹³ Freudenberg, ‘Lethal but Legal’ (n 147) 131.

Building on the definitions, historical evolution, and key characteristics of earlier PPP models, this research defines PPPs for NCD prevention as voluntary collaborations between the public sector (government entities) and the for-profit sector (food corporations) to address the challenges imposed by NCDs with the common aim of public health promotion via some degree of shared decision-making. These partnerships may also include nonprofit and civil society actors.

A critical aspect of this definition is the voluntary nature of the collaboration and the unique challenge posed by the involvement of risk-creating industries whose profit motives conflict with public health goals. Thus, PPPs for NCD prevention differ from traditional PPPs due to the private sector's misalignment with the common goal (public health promotion). In addition, the idea of "sharing risks and benefits" is notably absent in PPPs for NCD prevention. In practice, private actors secure the benefits without bearing meaningful risks, while the public sector assumes significant risks to public health with little to no corresponding benefit.

Moreover, these PPPs have a wide diversity in their structure (how the industry engages) and decision-making dynamics. Voluntary reformulation agreements, such as the Declaration of Milan, grant industry representatives a seat at the table, allowing them to shape key decisions, including the extent of product reformulation. The form of agreement also differs. The Declaration of Milan was established through a memorandum of understanding, reflecting a negotiation solution, whereas the Danish Whole Grain Partnership follows a more formalized structure, with a board of representatives resembling the governance model of global health partnerships.

PPPs for NCD prevention generally tend to be effective only when industry interests align with public health objectives, as seen in the Danish Whole Grain Partnership, an institutionalized scheme with shared governance. By contrast, the UK Responsibility Deal illustrates the pitfalls of misalignment, with its loose structure, lacking defined measurable targets, robust monitoring, enforceable consequences, and authority oversight, limiting its capacity to promote public health. Similarly, the voluntary sodium reduction targets in the US underscore the risks of relying on industry goodwill, given the absence of systematic monitoring, accountability, and penalties for non-compliance. The Declaration of Milan, a PPP formalized through a memorandum of understanding that includes defined targets and a termination clause, might appear promising. However, without strong oversight by authorities and enforceable consequences, such frameworks remain largely symbolic and insufficient to drive meaningful compliance.

Public-private partnerships in general highlight the idea that private solutions (market mechanisms) are generally privileged over public approaches. As a result of neoliberalism, PPPs redraw the boundaries between the public and private spheres and entrench private interests within an “ever-shrinking” public sphere. For example, global health public-private partnerships allowed corporations to maintain their influence in global health, expand into new markets, and connect with new consumers globally.¹⁶¹⁴ In the context of PPPs for NCD prevention, the boundaries between the public and private spheres are also blurred and intensified by the idea that private parties are lobbying for voluntary collaborations as an avoidance mechanism to stricter regulations for public health promotion.

PPPs with multinational food corporations present significant obstacles to public health objectives. In the majority of cases, these partnerships do not achieve their goals and are frequently used to hinder or delay the implementation of public health regulations. Thus, from a normative perspective, these partnerships defy their own purpose of “public health promotion” and “NCD prevention”, challenging the role of private actors in advancing public health. This misalignment highlights the limitations of PPPs as an alternative regulatory tool in addressing complex public health challenges.

¹⁶¹⁴ Ruckert and Labonté, ‘Public–Private Partnerships (PPPs) in Global Health’ (n 1098).

PART 4

**RETHINKING LEGAL FRAMEWORKS AND PATHWAYS FORWARD FOR
PUBLIC-PRIVATE PARTNERSHIPS**

NCDs impose substantial burdens on healthcare systems worldwide, with unhealthy diets being one of their primary risk factors. Since these diseases are preventable, legal responses have been advanced to tackle the risks associated with their development. As a result of soft law at the international level, states have implemented limited command-and-control regulations, which have raised paternalistic critiques of a perceived “state intrusion” into individual choices. At the same time, the rise of public-private partnerships in general and within global health governance has been closely linked to broader neoliberal narratives that question the efficiency of the public sector and promote the involvement of private actors in addressing public challenges.

This environment has thus created fertile ground for positioning PPPs as an “innovative alternative regulatory tool” for NCD prevention, with the idea that private sector participation can bring expertise, resources, and efficiency.

However, these partnerships raise significant legal concerns, particularly due to conflicts of interest inherent in involving industries that are themselves major contributors to public health risks. Industries responsible for producing and marketing products that drive NCDs are now paradoxically positioned as partners in efforts to mitigate these very harms.

Additionally, different from PPPs in general, these collaborations operate in a legal gray zone. This highlights that, while PPPs for NCD prevention are rooted in the same ideological foundations as traditional and global health PPPs, they operate very differently and lack a legal framework.

Furthermore, despite parallels with other risk-creating sectors, most notably tobacco, the legal treatment of the food and beverage industries remains very different. Unlike the approach towards tobacco control, which explicitly excludes the tobacco industry from participating as a partner in public health initiatives, international and domestic frameworks continue to endorse engagement and collaboration with food and beverage companies in addressing diet-related NCDs.

Against this backdrop, this part explores two main hypotheses, one situated at the practical legal level and the other developed at the theoretical level regarding the establishment of PPPs for NCD prevention. The first hypothesis suggests that as private entities have become increasingly involved in providing public goods, PPPs are expanding into diverse fields, including collaborations with the food industry for public NCD prevention. This view is supported by domestic case studies within the thesis, such as the US Voluntary Sodium Reduction Goals

which sets voluntary sodium targets to encourage food manufacturers to lower sodium content across the food supply through reformulation, and Switzerland's Declaration of Milan, a voluntary collaboration between food industries and the Swiss Government to reduce sugar content in various food categories. Additionally, an in-depth examination of the international framework reveals that many global instruments encourage private-sector engagement in the context of NCDs and public health promotion. However, the challenge lies in establishing a robust regulatory framework that addresses human rights principles, such as accountability and transparency, and includes stringent compliance mechanisms. Drawing on models from other domains, this hypothesis suggests that adapting legal elements from established PPP frameworks may offer pathways to collaborations in the public health domain.

The second hypothesis takes a critical theoretical perspective, arguing that the inherent conflicts of interest within the food industry undermine public health objectives, particularly given that these companies are the risk creators for obesity, diabetes, and other NCDs through their unhealthy products. Taking the regulatory approach toward the tobacco industry as an analogous example, this hypothesis understands the exclusion of food industry actors from direct involvement in public health initiatives due to their potential to undermine policy efforts. This part explores the concept of "denormalization" as a legal and social tool to shift norms around unhealthy food production and consumption, aiming to reduce industry influence on public health agendas. The Fourth United Nations High-Level Meeting on NCDs in 2025 is an opportunity for this. If there is a shift at the international level, it can directly impact domestic regulations and change the normalization of Big Food and Big Soda participation in public-health decision making.

CHAPTER 12: BUILDING ROBUST PPPs FOR NCD PREVENTION

I Framework for PPPs for NCD prevention

The vast body of scientific literature demonstrates that public-private partnerships are not an effective tool for genuinely addressing NCD prevention and public health promotion.¹⁶¹⁵ Furthermore, the analysis of case studies reveals that PPPs for NCD prevention often fail to achieve their intended goals.¹⁶¹⁶ Instead, industries frequently employ these partnerships as mechanisms to avoid regulation towards their unhealthy products. Thus, from a normative perspective, PPPs for NCD prevention mostly fall short of effectively promoting public health and preventing NCDs, consequently, this dynamic defies its own normative purpose. Despite these shortcomings, many countries continue to adopt various forms of these collaborations, such as voluntary agreements focused on product reformulation, as a strategy for NCD prevention.

Moreover, in the context of NCD prevention, most of the current instruments at the international framework call for private-sector engagement. Thus, as has been noted, “PPPs are here to stay”.¹⁶¹⁷ Therefore, adopting a legal framework to avoid the preponderance of profit motives over public health interests is crucial.¹⁶¹⁸ Also, GOSTIN has pointed out that “the private sector is a vital part of the problem and at the same time part of the solution”.¹⁶¹⁹ Accordingly, he highlights the necessity of robust corporate regulation.¹⁶²⁰

To move beyond the legal gray zones that often characterize voluntary partnerships in NCD prevention, this section proposes a more robust framework for the establishment of these PPPs. It will begin by outlining existing principles stipulated in the international instruments, mostly from UN documents concerning the engagement with the private sector. Then it will explore

¹⁶¹⁵ Hernandez-Aguado and Zaragoza, ‘Support of Public–Private Partnerships’ (n 1210); Moodie and others, ‘Profits and Pandemics’ (n 34); Buse, Tanaka and Hawkes, ‘Healthy People and Healthy Profits?’ (n 35); Parker, Zaragoza and Hernández-Aguado, ‘Promoting Population Health with Public-Private Partnerships’ (n 1197); Knai and others, ‘Has a Public–Private Partnership Resulted in Action’ (n 1292); Crosbie and Carriedo, ‘Applying a Commercial Determinants of Health Lens’ (n 35); Clapp and Scrinis, ‘Big Food, Nutritionism, and Corporate Power’ (n 1195).

¹⁶¹⁶ Part 3, Chapter 10, II.

¹⁶¹⁷ Hernandez-Aguado and Zaragoza, ‘Support of Public–Private Partnerships’ (n 1210).

¹⁶¹⁸ Belinda Reeve and Lawrence O Gostin, “‘Big’ Food, Tobacco, and Alcohol: Reducing Industry Influence on Noncommunicable Disease Prevention Laws and Policies Comment on “Addressing NCDs: Challenges from Industry Market Promotion and Interferences”” (2019) 8 *International Journal of Health Policy and Management* 450.

¹⁶¹⁹ Gostin, *Global Health Law* (n 3) 408.

¹⁶²⁰ *ibid.*

the attempts of non-legal scholars to provide different recommendations when engaging in partnerships with the food and sweetened beverage industry. Next, it will analyze the key human rights principles for establishing and operating PPPs. In addition, it will include a business and human rights approach to the food industry in the context of NCD prevention. Finally, building on examples from other PPP legal frameworks, it will propose a formal contract to structure PPPs for NCD prevention.

1 Transplanting principles from the UN scope

This section will present provisions and principles from different instruments in the international framework that could be replicated in the establishment of PPPs for NCD prevention.

Guidelines on a principle-based Approach to the Cooperation between the United Nations and the Business Sector

At the UN level, the “Guidelines on a principle-based Approach to the Cooperation between the United Nations and the Business Sector” is a leading document for partnerships between the UN and the industry. These guidelines define a partnership as “a voluntary and collaborative agreement or arrangement between one or more parts of the United Nations system and the business sector, in which all participants agree to work together to achieve a common purpose or undertake a specific task and to coordinate their respective responsibilities, resources, and benefits”.¹⁶²¹ The term “business sector” encompasses sector for-profit as well as business associations and coalitions, whether cross-industry or focused on specific issues or industries.¹⁶²²

The guidelines stress the importance of clearly delineating the roles and responsibilities of each partner. It emphasizes that the partnership should have goals, objectives, proposed activities foreseen, identification of all participants, especially in multi-stakeholder processes, and a governance structure to ensure transparency and accountability.¹⁶²³

¹⁶²¹ UN Global Compact, *Guidelines on a Principle-based Approach* (n 1057) para 8(a).

¹⁶²² *ibid*, para 8(b).

¹⁶²³ *ibid*, para 12.

Moreover, the guidelines emphasize that partnerships should be implemented by a formal written agreement between the private entity and the United Nations, adhering to the relevant UN regulations and rules. Such agreements must outline clear roles, expectations, responsibilities, resource allocation, and benefits for each party, ensuring accountability and effective coordination. They should also include defined timelines and measurable outputs to track progress.¹⁶²⁴

United Nations System Standing Committee on Nutrition Private Sector Engagement Policy

Still at the UN level, in 2006, the United Nations System Standing Committee on Nutrition (UNSCN) created the SCN Private Sector Engagement Policy, which sets rules for engaging with the private sector on the nutrition scenario.¹⁶²⁵ The principles for engagement include alignment of the partnership with UNSCN's vision and mandate, the partnership's effectiveness and efficiency in advancing UNSCN's objectives, conflict of interest management, encompassing identification of partner interests, assessment of potential conflicts, and, where necessary, exclusion as a precautionary measure, safeguarding independence from vested interests to uphold credibility, transparency, fostering diversity to avoid preferential treatment of any specific type of private sector organization, implementing differential safeguards to protect public policymaking activities from corporate influence, and upholding and promoting human rights principles.¹⁶²⁶

While certain principles, such as the emphasis on human rights, reflect UNSCN's role as a UN entity, these guidelines also emphasize a set of basic principles for public partners to establish criteria for evaluating public-private partnerships.

Food and Agriculture Organization

On the scope of the FAO, FAO's Strategy for private sector engagement 2021-2025 has as a vision "Leaving No One Behind through sustainable, inclusive and resilient food systems for

¹⁶²⁴ *ibid*, para 13.

¹⁶²⁵ The Standing Committee on Nutrition (SCN) is the UN's policy harmonization forum for food and nutrition, aiming to eliminate hunger and malnutrition as barriers to human development. Currently its identified as United Nations Standing Committee on Nutrition (UNSCN).

¹⁶²⁶ UN System Standing Committee on Nutrition, SCN Private Sector Engagement Policy (interim document, March 2006, revised 19 June 2006).

better production, better nutrition, a better environment, and a better life”.¹⁶²⁷ FAO aims to bring strategic partnerships and collective multi-stakeholder efforts to achieve the SDGs, particularly SDG 1 (eradicating poverty) and SDG 2 (on Zero Hunger).¹⁶²⁸ Even though SDG 3.4 is neglected from the scope of the FAO Strategy, it is possible to establish links between this strategy and the context of PPPs for NCDs prevention. In addition, one of the areas of engagement identified in the strategy is “partnering for healthy diets and to eradicate all forms of malnutrition (including obesity)”.¹⁶²⁹

The strategy adopts the definition of partnership from the UNSDG Common Approach to Prospect Research and Due Diligence for Business Sector Partnerships, which characterizes private sector engagement as “any type of interaction with business entities, encompassing a range of objectives, from informal talks and discussions to knowledge-exchange platforms and comprehensive partnerships involving funding”.¹⁶³⁰ These engagements can take various forms, including but not limited to collaboration, and may involve varying degrees of public visibility. The UNSDG emphasizes that partnerships are generally founded on a mutually agreed commitment, such as a letter of appreciation, memorandum of understanding, or other legal agreements. However, the level of formality and specificity can differ.¹⁶³¹

The principles of engagement include having a tangible contribution to achieving the Sustainable Development Goals, upholding the values of the FAO and the United Nations, ensuring that FAO’s neutrality, impartiality, integrity, independence, credibility, and reputation remain uncompromised, be effectively managed to avoid conflicts of interest or other risks to FAO, align with and contribute to FAO’s mandate, goals, and mission, as well as the national development objectives of its Member States, respect the intergovernmental character of FAO and the decision-making authority of its Members, as outlined in its Constitution, enhance and safeguard FAO’s neutral, independent, and evidence-based scientific approach, protect FAO from undue influence, particularly in the processes of policy development and the establishment and application of norms and standards; and adhere to principles of transparency, openness, inclusiveness, accountability, integrity, and mutual respect.¹⁶³² It highlights that these principles will be integrated into appropriate legal instruments and mechanisms/modalities for the

¹⁶²⁷ Food and Agriculture Organization, *FAO’s Strategy for Private Sector Engagement 2021–2025* (2021)

¹⁶²⁸ *ibid*, para 18.

¹⁶²⁹ *ibid*, para 30.

¹⁶³⁰ United Nations Sustainable Development Group, *Common Approach to Prospect Research and Due Diligence for Business Sector Partnerships* (March 2020).

¹⁶³¹ *ibid*.

¹⁶³² FAO, *Strategy for Private Sector Engagement* (n 1627) para 19.

engagements.¹⁶³³ This point is crucial to be transplanted to PPPs for NCD prevention, first, the reinforcement of the idea on an appropriate legal instrument, and second, principles such as the respect for the decision-making authority and the protection from undue influence, particularly in policy development processes. Again, human rights principles like transparency and accountability are cited here.

The Strategy also incorporates principles of due diligence. It is important to note, however, that the Strategy includes a provision regarding “disengagement and non-compliance”, granting the FAO the right to terminate partnerships in cases of prolonged inactivity or lack of cooperation between FAO and the partner, or when the partner fails to fulfill their financial or programmatic obligations as outlined in this Strategy.¹⁶³⁴ Non-compliance may involve actions that align with FAO’s exclusion criteria, such as using the partnership for purposes unrelated to FAO’s mandate (e.g., commercial, promotional, marketing, or advertising objectives), improper use of FAO’s name or emblem, or any conduct by the partner that could jeopardize FAO’s integrity, independence, credibility, reputation, or mandate. A private sector entity’s failure to comply with the Strategy’s provisions may result in consequences following due process, including reminders, warnings, or cease-and-desist orders.¹⁶³⁵

The Strategy also establishes that monitoring will include an annual strategic review of all partnerships, focusing on assessing achievements and identifying needs for support or practical guidance to enhance engagement and manage risks.¹⁶³⁶ Incorporating this element of regular revision, whether annually or at another period, into PPPs for NCD prevention is crucial, as it provides a consistent framework for evaluating what is working well and addressing areas requiring improvement.

Finally, it is crucial to emphasize that in developing FAO’s Strategy for Private Sector Engagement, the Organization conducted an “extensive virtual consultation process, seeking input from private sector companies and business organizations”.¹⁶³⁷ This consultation included major companies such as Mars, Nestlé, Danone, PepsiCo, Unilever, Mondelez, and Ferrero, as well as industry associations like the Alianza Latinoamericana de Asociaciones de Industria

¹⁶³³ *ibid.*

¹⁶³⁴ *ibid.*, para 56.

¹⁶³⁵ *ibid.*, para 57.

¹⁶³⁶ *ibid.*, para 63.

¹⁶³⁷ *ibid.*, annex 3: Virtual consultations with the private sector.

Alimentaria y Bebidas and FoodDrinkEurope.¹⁶³⁸ This raises an important question about these industries' influence in shaping key documents that guide partnerships with the same industries.

Key principles

From the UN framework, several key principles for public-private partnerships can be transplanted. These include a strong emphasis on respecting human rights and the critical importance of clearly defining the roles and responsibilities of all partners. This clarity should encompass the partnership's goals, objectives, proposed activities, and a comprehensive identification of all participants formalized in a written agreement. Additionally, principles such as transparency, accountability, thorough due diligence to identify and address conflicts of interest, and ongoing monitoring are fundamental to ensuring the effectiveness and integrity of these collaborations. Finally, the appropriate legal instruments and mechanisms/modalities for guiding the engagement.

2 Literature

The literature offers various attempts to develop principles for establishing PPPs in food and nutrition or assessing the ethics of such collaborations. For instance, GALEA and MCKEE have presented five tests for engagement in such public-private partnerships.¹⁶³⁹ The first test assesses whether the corporation's core products and services are health-enhancing or health-damaging. To establish credibility, corporations must explicitly acknowledge that some of their products may have adverse health impacts and publicly commit to measures aimed at mitigating these harms.¹⁶⁴⁰ Conversely, if a corporation denies the harmful effects of its products, such as the sugar industry's historical approach, it raises significant doubts about its suitability as a partner in public health initiatives.¹⁶⁴¹

¹⁶³⁸ *ibid*, annex 3: Virtual consultations with the private sector.

¹⁶³⁹ Gauden Galea and Martin McKee, 'Public-Private Partnerships with Large Corporations: Setting the Ground Rules for Better Health' (2014) 115 *Health Policy* 138.

¹⁶⁴⁰ *ibid*.

¹⁶⁴¹ *ibid*.

The second test examines whether potential partners implement robust policies within their own operations, such as adhering to labor, health, and safety standards across the countries in which they operate.¹⁶⁴² This reflects their commitment to ethical and health-conscious practices.

The third test concerns potential partners' CSR activities.¹⁶⁴³ CSR initiatives are often used as marketing strategies to boost brand recognition and product acceptability. To address this, the authors suggest developing a register of claimed social and health benefits, which would be subject to independent external review.¹⁶⁴⁴

The fourth test considers whether corporations make meaningful contributions to the commons. The authors propose establishing legal frameworks for "public commons" where corporations contribute resources and over which they concede control. These contributions must be structured to prevent them from becoming de facto bribes. They conclude that a corporation's history in this regard could indicate whether it genuinely acts in the public interest. Still, such contributions should never be conditional on securing contracts or specific PPP engagements.¹⁶⁴⁵

The final test focuses on the role corporations should play in policymaking.¹⁶⁴⁶ The authors highlight that governments must retain their responsibility for policy-making and ensure that corporations do not exert undue influence. However, corporations can play a legitimate role in consultations regarding the implementation of evidence-based public health policies.¹⁶⁴⁷

In developing a governance typology for public-private engagement in the nutrition sector, PATAY and others emphasize the limiting industry influence in policymaking, in which policymakers should design governance arrangements that restrict food industry actors' involvement in formal decision-making during critical stages of the policy cycle.¹⁶⁴⁸ Moreover, it highlights that civil society actors should have equivalent or greater influence, supported by clear rules that regulate institutional power. They also identify that policymakers should critically assess which industry actors to engage, considering their existing powers, interests, and the potential risks they pose to public health goals.¹⁶⁴⁹

¹⁶⁴² *ibid.*

¹⁶⁴³ *ibid.*

¹⁶⁴⁴ *ibid.*

¹⁶⁴⁵ *ibid.*

¹⁶⁴⁶ *ibid.*

¹⁶⁴⁷ *ibid.*

¹⁶⁴⁸ Patay and others, 'Fifty Shades of Partnerships' (n 35).

¹⁶⁴⁹ *ibid.*

In conclusion, the authors identify that limiting industry engagement to the implementation stage of policies, rather than their design or formulation, helps curtail opportunities for corporations to influence policy content in ways that may undermine public interests.¹⁶⁵⁰ Additionally, involving civil society actors in monitoring and evaluation processes enhances the transparency and accountability of PPPs.¹⁶⁵¹

According to KRAAK and others, six challenges should be considered in PPPs to diminish the risks resulting from such partnerships in public health. They identify the balance between private interests and public health interests; management of conflicts of interests and biases; ensuring that associations in the use of trademarks support healthy products and environments; compliance with ethical codes of conduct; due diligence to assess the partnership's compatibility; and follow-up and evaluation of the partnership's results.¹⁶⁵²

MARKS emphasizes the need for caution when engaging corporations in matters of the common good.¹⁶⁵³ While he acknowledges that corporations can contribute positively, he asserts that they are not the guardians of the common good and that responsibility lies with government agencies and intergovernmental bodies. MARKS warns against mixing corporate commercial interests with the common good and alerts policymakers against assuming that finding common ground with industry actors inherently advances public welfare.¹⁶⁵⁴ He further argues that collaboration with corporations can jeopardize the core functions of public institutions, hinder their ability to serve the public good, compromise their integrity, and diminish public trust. To safeguard their independence, credibility, and integrity, MARKS advocates for developing strategies to shield public institutions from undue industry influence.¹⁶⁵⁵ His strategy proposes six principles: independence, integrity, credibility, stewardship, public good, and anti-promotion.¹⁶⁵⁶ According to MARKS, the principles, individually and cumulatively, reinforce his view that the default interaction between public and private sector entities should be characterized by arm's-length relationships.¹⁶⁵⁷

He argues that there “should be a strong presumption against (rather than in favor of) close relationships with industry in public health intervention”.¹⁶⁵⁸ Furthermore, he advocates

¹⁶⁵⁰ *ibid.*

¹⁶⁵¹ *ibid.*

¹⁶⁵² Kraak and others, ‘Balancing the Benefits and Risks of Public–Private Partnerships’ (n 1178).

¹⁶⁵³ Marks, *The Perils of Partnership* (n 1188) 34.

¹⁶⁵⁴ *ibid.*, 34.

¹⁶⁵⁵ *ibid.*, 101.

¹⁶⁵⁶ *ibid.*, 114

¹⁶⁵⁷ *ibid.*, 119.

¹⁶⁵⁸ *ibid.*, 126.

abandoning the term partnership, as it may exacerbate the risks of asymmetric reciprocity.¹⁶⁵⁹ Instead, he proposes that such collaborations should be replaced by arm's-length relationships, which maintain greater independence.¹⁶⁶⁰

The concept of arm's length has been employed in legal contexts, such as tax and competition law. In the scope of nutrition, it has also been described as a key concept to ensure transparency in managing conflicts of interest. Arm's length in the scenario of managing conflict of interest is defined as "independent from the other entity, does not take instructions from it, and is clearly not influenced and not reasonably perceived to be influenced in its decisions and work by the other entity."¹⁶⁶¹ In summary, the arm's length principle is crucial in preventing COI because it preserves the independence and integrity of public health efforts, ensuring that the food industry cannot exert direct or indirect control or influence over public health research and policy-making.

Focusing on voluntary agreements for food reformulation, REEVE and MAGNUSSON proposed a "regulatory scaffolds" framework.¹⁶⁶² The framework focuses on the regulatory content, process, and enforcement. Regarding content, they stress the importance of establishing clear objectives and measurable targets, enabling the evaluation of food reformulation initiatives' progress toward the goals and facilitating comparisons among participating companies.¹⁶⁶³ In terms of the regulatory process, they emphasize the value of independent monitoring and evaluation to enhance transparency and accountability. Lastly, for enforcement, they suggest a combination of incentives, such as positive publicity or subsidies, and disincentives for non-compliance, including fines, "naming and shaming," and the potential for government intervention, to encourage compliance.¹⁶⁶⁴

The literature also emphasizes transparency and accountability and draws attention to private influence in public decision-making.¹⁶⁶⁵ In addition, appropriate targets, independent monitoring, transparent reporting, and management of conflict of interest have been

¹⁶⁵⁹ *ibid.*, 122-123.

¹⁶⁶⁰ According to the Cambridge dictionary, arm's-length is used to describe a situation in which two people, companies, etc. operate separately from each other. 'arm's-length' (Cambridge Business English Dictionary) <<https://dictionary.cambridge.org/dictionary/english/arm-s-length>> accessed 5 June 2025.

¹⁶⁶¹ WHO, EB142/23 (n 1558) para 14.

¹⁶⁶² Roger Magnusson and Belinda Reeve, 'Food Reformulation, Responsive Regulation, and "Regulatory Scaffolding": Strengthening Performance of Salt Reduction Programs in Australia and the United Kingdom' (2015) 7 *Nutrients* 5281.

¹⁶⁶³ *ibid.*

¹⁶⁶⁴ *ibid.*

¹⁶⁶⁵ Reeve and Gostin, "'Big' Food, Tobacco, and Alcohol" (n 1618).

underscored.¹⁶⁶⁶ Conflict of interest is mentioned several times when addressing collaboration with the private sector.

3 Human rights principles for the establishment of PPPs

Human rights principles should form the foundation of PPPs in public health. Transparency ensures that all stakeholders, including the public, have access to information about the partnership's goals, processes, and outcomes. Accountability mechanisms ensure that private and public actors are held responsible for their commitments, fostering trust and credibility. By embedding these principles into the structure of PPPs, governments can navigate the inherent tensions between public health objectives and private sector interests.

3.1 Transparency

Transparency is consistently cited as a foundational principle in establishing public-private partnerships.¹⁶⁶⁷ For instance, within the FENSA scope, WHO affirms that its interaction with non-state actors is managed by transparency.¹⁶⁶⁸ The UN guidance on partnerships with the private sector highlights that “cooperation with the business sector must be transparent”.¹⁶⁶⁹ Moreover, guidance documents emphasize its importance, and the scientific literature on collaborations with the food industry underscores that transparency is essential for the success of any partnership.¹⁶⁷⁰ But what does transparency truly entail, and how does it apply specifically to PPPs for NCD prevention?

The UNCITRAL Legislative Guide on Public-Private Partnerships identifies transparency as a core principle for creating a robust legal framework for PPPs. According to this guide, “a transparent legal framework is characterized by clear and readily accessible rules and efficient procedures for their application”.¹⁶⁷¹ In this context, transparency involves publishing administrative decisions and, where appropriate, requiring justification for these decisions. It also includes the disclosure of other information relevant to the public.¹⁶⁷²

¹⁶⁶⁶ Buse, Tanaka and Hawkes, ‘Healthy People and Healthy Profits?’ (n 35).

¹⁶⁶⁷ This includes all types of PPPs (original formal, global health PPPs and PPP for NCD prevention).

¹⁶⁶⁸ WHO, ‘FENSA’ (n 1527).

¹⁶⁶⁹ UN Global Compact, *Guidelines* (n 1621) para 25.

¹⁶⁷⁰ Belinda Reeve and Roger Magnusson, “‘Legislative Scaffolding’: A New Approach to Prevention’ (2013) 37 Australian and New Zealand Journal of Public Health 494.

¹⁶⁷¹ UNCITRAL, *Legislative Guide on Public-Private Partnerships* (n 1073) 27.

¹⁶⁷² *ibid.*

In the original format of PPPs, transparent rules are integral to ensuring effective monitoring and fostering accountability.¹⁶⁷³ By making key information available and accessible, transparency helps build trust among stakeholders and promotes informed public oversight. However, transparency is lacking in the context of PPPs for NCD prevention.¹⁶⁷⁴

At the UN level, the UN Global Compact's Guidelines on a Principle-Based Approach to Cooperation Between the United Nations and the Business Sector specify that details regarding the nature and scope of significant collaborative arrangements should be accessible within the relevant UN entity and to the general public. The respective UN entities are encouraged to share this information on their websites and to publish relevant details on the United Nations/business-specific online platform.¹⁶⁷⁵

Moreover, transparency is recognized as a foundation of democracy in the context of PPPs for global health, particularly because these partnerships aim to achieve public interest objectives.¹⁶⁷⁶ In a democratic society, the public has the right to be informed about processes and decisions that affect them.¹⁶⁷⁷ This principle is equally applicable to PPPs in NCD prevention. The public should have access to information about initiatives concerning one of our most fundamental needs: food. Finally, this also enhances the accountability of the parties involved in the partnership.

3.2 Accountability

Accountability is often discussed alongside transparency in international frameworks and scholarly literature aiming to define principles for partnerships with the food industry. In the traditional term, accountability implies a relational dynamic in which certain individuals or entities are obligated to justify and take responsibility for their actions, encapsulated in the concept of “giving and demanding reasons for conduct”.¹⁶⁷⁸ Accountability has evolved into a

¹⁶⁷³ *ibid.*

¹⁶⁷⁴ This can be seen in the case studies presented in Part 3, Chapter 10, II Case studies: public-private partnerships with ultra-processed food and the sweetened beverage industries.

¹⁶⁷⁵ UN Global Compact, *Guidelines* (n 1621) para 25.

¹⁶⁷⁶ Michael R Reich, ‘The Core Roles of Transparency and Accountability in the Governance of Global Health Public–Private Partnerships’ (2018) 4 *Health Systems & Reform* 239.

¹⁶⁷⁷ *ibid.*

¹⁶⁷⁸ Jean Shaoul, Anne Stafford and Pamela Stapleton, ‘Accountability and Corporate Governance of Public Private Partnerships’ (2012) 23 *Critical Perspectives on Accounting* 213.

multi-dimensional concept that encompasses accountability, holding to account, and imposing consequences.¹⁶⁷⁹

In the public sector, accountability has been analyzed through three aspects: first, compliance, being held to account; second, transparency, giving an account; and third, responsiveness, taking into account.¹⁶⁸⁰

In summary, accountability can be understood as “the concept of accountability implies that the actors being held accountable have obligations to act in ways that are consistent with accepted standards of behavior and that they will be sanctioned for failures to do so”.¹⁶⁸¹ Accountability has been characterized as a normative framework, a set of principles guiding the evaluation of conduct, and a structural mechanism, defined as an institutional arrangement in which one agent or institution holds another accountable.¹⁶⁸² It has also been divided into key dimensions: answerability and enforceability. Answerability relates to the relations involved in accountability, addressing questions such as “who is accountable to whom?”, it also encompasses standards or the criteria against which performance is measured (accountability for what), and judgments, the process of evaluating whether those standards have been met (how accountability is assessed).¹⁶⁸³

Enforceability focuses on the application of sanctions, which may take the form of legal, reputational, or financial penalties when standards are not upheld. It also involves redress, which concerns the scope and methods for addressing liability and providing compensation for harm resulting from failures to meet those standards.¹⁶⁸⁴ Here, related to aspects of judicial review, as a mechanism for holding public bodies accountable.

In the context of PPPs, an essential concept to examine is corporate accountability, particularly from a business and human rights perspective. First, it is crucial to differentiate between corporate social responsibility and corporate accountability.¹⁶⁸⁵ Corporate accountability is related to an enforceable framework designed to shape corporate behavior. Unlike approaches that rely on companies’ voluntary commitments to pursue socially beneficial goals, corporate

¹⁶⁷⁹ *ibid.*

¹⁶⁸⁰ *ibid.*

¹⁶⁸¹ Ruth W Grant and Robert O Keohane, ‘Accountability and Abuses of Power in World Politics’ (2005) 99 *American Political Science Review* 29.

¹⁶⁸² Nadia Bernaz, ‘Conceptualizing Corporate Accountability in International Law: Models for a Business and Human Rights Treaty’ (2020) 22 *Human Rights Review* 45.

¹⁶⁸³ *ibid.*

¹⁶⁸⁴ *ibid.*

¹⁶⁸⁵ For a detail analyses of CSR, see Part 2, Chapter 8, IV.

accountability emphasizes the creation of institutional structures that ensure companies are answerable for their actions.¹⁶⁸⁶

Corporate accountability has been used as a mechanism to mitigate or prevent the adverse impacts of business activity on individuals and communities, driven by expectations rooted in fundamental human rights obligations.¹⁶⁸⁷ In the context of unhealthy foods, it can play a pivotal role in mitigating harmful impacts and ensuring responsible practices within PPPs involving the food industry. This idea is intrinsically tied to the principle of due diligence, emphasizing accountability and adherence to ethical standards in such collaborations.

Thus, accountability is critical in ensuring that a PPP fulfills its public interest objectives while enhancing organizational performance. By holding the partnership and its partners accountable, stakeholders can evaluate whether the intended public goals are being met and, if not, identify necessary actions to improve outcomes.¹⁶⁸⁸

3.3 Due diligence

Due diligence can be explored in two distinct ways. First, on the idea of the process undertaken by the public sector before entering into a partnership with the private sector. For instance, at the international level, WHO FENSA stipulates, “Before engaging with any non-State actor, WHO, in order to preserve its integrity, conducts due diligence and risk assessment.”¹⁶⁸⁹ WHO defines due diligence as the process of gathering and verifying relevant information about a non-State actor to develop a comprehensive understanding of its profile. This process involves reviewing information provided by the entity, conducting independent research from various sources, and analyzing the collected data. Key resources for this review include public records, legal and commercial databases, media reports, company profiles, and governmental sources.¹⁶⁹⁰

¹⁶⁸⁶ Min Yan and Daoning Zhang, ‘From Corporate Responsibility to Corporate Accountability’ (2020) 16 *Hastings Business Law Journal*.

¹⁶⁸⁷ Steven R Ratner, ‘Corporations and Human Rights: A Theory of Legal Responsibility’ (2001) 111 *The Yale Law Journal* 443.

¹⁶⁸⁸ Reich, ‘The Core Roles of Transparency and Accountability in the Governance of Global Health Public–Private Partnerships’ (n 1676).

¹⁶⁸⁹ WHO, ‘FENSA’ (n 1527).

¹⁶⁹⁰ *ibid*, para 30.

Along the same lines, FAO’s Strategy for private sector engagement establishes that “before engaging with any private sector entity, FAO conducts due diligence and risk assessments to preserve its integrity”.¹⁶⁹¹

At the United Nations level, the UNSDG Common Approach to Prospect Research and Due Diligence for Business Sector Partnerships provides a framework for evaluating partnerships with private entities.¹⁶⁹² Although its focus is on UN collaborations, it offers significant insights for applying due diligence to public-private partnerships for NCD prevention. This framework defines due diligence as “a set of criteria, parameters, and analytical practices used to evaluate the risks and benefits associated with potential interactions and associations with business entities.”¹⁶⁹³ It emphasizes that due diligence assessments and their recommendations are integral to partnership prospecting, decision-making, and risk management.¹⁶⁹⁴ Finally, it underscored that a robust due diligence process enhances the understanding of the risks and opportunities involved in engaging with a prospective partner”.¹⁶⁹⁵

The UNSDG Common Approach delineates the essential components of a due diligence assessment. These include: researching the business profile of a prospective partner; conducting an initial screening against exclusionary criteria¹⁶⁹⁶ and categorizing potential partners based on risk levels to determine the depth of due diligence required; applying additional exclusionary criteria tailored to the specific mandate and risk tolerance of individual UNSDG member organizations; performing a risk-benefit analysis that assesses the partner’s integrity and the potential impact of the partnership; identifying strategies to prevent, mitigate, or manage risks; and making a final decision, which may involve escalation to higher levels of authority when necessary.¹⁶⁹⁷

Furthermore, due diligence is also a principle of states’ responsibility under international human rights law.¹⁶⁹⁸

¹⁶⁹¹ FAO, *Strategy for Private Sector Engagement* (n 1627) para 54.

¹⁶⁹² UNSDG, *Common Approach to Prospect Research and Due Diligence* (n 1630).

¹⁶⁹³ *ibid.*

¹⁶⁹⁴ *ibid.*

¹⁶⁹⁵ *ibid.*

¹⁶⁹⁶ It is important to observe that the exclusionary criteria include business practices colliding with UN Resolutions, tobacco and alcohol industries, and even company practices not compliant with the International Code of Marketing of Breast-milk Substitutes. However, they do not encompass measures about the food and sweetened beverage industries.

¹⁶⁹⁷ UNSDG, *Common Approach to Prospect Research and Due Diligence* (n 1630).

¹⁶⁹⁸ Robert Barnidge, ‘The Due Diligence Principle under International Law’ (2006) 8 *International Community Law Review* 81.

Due diligence is thus presented as a fundamental process to ensure that private-sector actors are evaluated for their capacity to identify, prevent, and address any potential adverse impacts on public health over the course of the partnership. However, this framework raises a critical question: if public-sector entities were to conduct a comprehensive and rigorous due diligence process, would they not conclude that industries such as food and sweetened beverages are inherently unsuitable partners for initiatives aimed at promoting public health? Furthermore, a review of domestic examples of PPPs reveals a notable gap: there is no available evidence of a due diligence process being conducted by the State in these partnerships.

4 Business and human rights framework

Another angle to analyze due diligence involves examining the private sector's responsibilities towards human rights. The Guiding Principles on Business and Human Rights: Implementing the United Nations Protect, Respect and Remedy Framework are widely recognized as the global standard on the business responsibility to respect human rights. The UNGPs emphasize that they are not to "be read as creating new international law obligations," but their objective is to "enhance standards and practices with regard to business and human rights to achieve tangible results for affected individuals and communities and thereby also contribute to socially sustainable globalization".¹⁶⁹⁹

The UN Guiding Principles are based on the three-pillar structure of the "Protect, Respect, and Remedy" elaborated by RUGGIE. Principle 11 emphasizes that "business enterprises should respect human rights," meaning "avoid infringing on the human rights of others and should address adverse human rights impacts with which they are involved".¹⁷⁰⁰ The human rights referred to at the UNGPs are the "internationally recognized human rights" which comprehend the rights of the Universal Declaration of Human Rights and the main instruments through which it has been codified, including the International Covenant on Economic, Social and Cultural Rights.¹⁷⁰¹ Thus, here is included the right to health and the right to adequate food.

Moreover, Principle 13 specifies that the responsibility to respect requires "avoid causing or contributing to adverse human rights impact through their own activities, and address such

¹⁶⁹⁹ United Nations Office of the High Commissioner for Human Rights, *Guiding Principles on Business and Human Rights: Implementing the United Nations 'Protect, Respect and Remedy' Framework* UN Doc A/HRC/17/31 (21 March 2011) (General principles).

¹⁷⁰⁰ UN OHCHR, *Guiding Principles* (n 1085) principle 11.

¹⁷⁰¹ *ibid*, principle 12.

impacts when they occur”.¹⁷⁰² Notably, the UNGPs’ Interpretive Guide published in 2012 cites “targeting high-sugar foods and drinks at children, with an impact on child obesity” as an example of such adverse impacts.¹⁷⁰³

Principle 17 introduces the concept of human rights due diligence, requiring businesses to identify, prevent, mitigate, and account for how they address adverse human rights impacts.¹⁷⁰⁴ This process includes assessing actual and potential impacts, acting on findings, tracking responses, and transparently communicating measures taken. The focus on business-related human rights issues is mainly centered on labor rights, including child labor, with increasing attention in recent years to environmental concerns.¹⁷⁰⁵ However, the adverse human rights impact of the corporate strategies by the food and sweetened beverage industries on the right to health and the right to adequate food is still a blind spot in the current business and human rights agenda.

The UN guiding principles framework operates on the idea of placing a responsibility on companies to respect human rights. However, the idea that corporations have obligations to human rights is growing. For instance, in the domain of environmental law, the *Milieudefensie et al. v. Royal Dutch Shell plc* case in which the Hague District Court, based on the unwritten standard of care, recognized the oil company’s direct obligation to a “healthy environment”.¹⁷⁰⁶ Thus, it is possible to establish human rights obligations of multinational food corporations to human rights.¹⁷⁰⁷ This analysis examines due diligence through a business and human rights lens to advance a more robust legal framework, proposing an innovative interpretation of private-sector obligations to the right to health and adequate food.

¹⁷⁰² *ibid*, principle 13.

¹⁷⁰³ UN Office of the High Commissioner for Human Rights, *The Corporate Responsibility to Respect Human Rights: An Interpretive Guide* (2012) 17.

¹⁷⁰⁴ UN OHCHR, *Guiding Principles* (n 1085) principle 17.

¹⁷⁰⁵ For instance, the *Milieudefensie et al. v. Royal Dutch Shell plc* case in which the Hague District Court, based on the unwritten standard of care, recognized the oil company’s direct obligation to a “healthy environment”.

¹⁷⁰⁶ *Milieudefensie et al v Royal Dutch Shell plc*, District Court of The Hague, 26 May 2021, Case No C/09/571932/HA ZA 19–379, para 4.1.

¹⁷⁰⁷ Alice Bryk Silveira, ‘Risk-Creating Industries’ Obligation to the Right to Health’ in Andreas R Ziegler, Damiano Canapa and Maria Izabel Cardozo (eds), *Business and Human Rights* (Brill | Nijhoff 2025).

4.1 Horizontal effect of human rights

In the classic approach of international law, the obligations emerging from international human rights are owed by the State in relation to the individual, constituting a vertical relation.¹⁷⁰⁸ The so-called “vertical effect of human rights law” is based on the concept that only States, as original subjects of international law, can become parties to human rights treaties and be legally bound by their obligations.¹⁷⁰⁹ On the other hand, the application of international human rights law between non-state actors is defined as the “horizontal effect” of human rights, and it can occur in a direct and indirect effect.

The direct horizontal effect would place non-State actors under direct and explicit obligations to respect, protect, and/or fulfill human rights, meaning that individuals would be able to claim violations of their rights directly to non-State actors.¹⁷¹⁰ This approach would empower individuals to claim their right to health directly to another non-state actor (here understood as private corporations). Under this scenario, individuals could claim their human rights when there is State inaction, for example, the absence of the adoption of measures to protect and fulfill the right to health and the right to adequate food.

Whereas in the indirect horizontal effect, the victim brings a claim of interference with their human rights (done by a non-State actor) to the State. Thus, the State remains directly responsible, and the non-state actor has indirect obligations.¹⁷¹¹ Still, to realize the indirect horizontal effect of human rights, States have the duty to adopt measures in order to prevent and address human rights violations by third parties. In the framework of global health law, General Comment 14 affirms that “States must take measures to prevent third parties from interfering with the right to health”.¹⁷¹² For instance, taxation and fiscal measures relating to tobacco and unhealthy foods, imposing marketing restrictions on tobacco, alcohol, foods, and sweetened beverages, and the adoption of front-of-package warning labeling. Moreover, it has been acknowledged that the State’s obligation to protect individuals’ right to health from violations of non-State actors includes the activities from private food corporations.¹⁷¹³

¹⁷⁰⁸ Lottie Lane, ‘The Horizontal Effect of International Human Rights Law in Practice: A Comparative Analysis of the General Comments and Jurisprudence of Selected United Nations Human Rights Treaty Monitoring Bodies’ (2018) 5 *European Journal of Comparative Law and Governance* 5.

¹⁷⁰⁹ *ibid.*

¹⁷¹⁰ *ibid.*

¹⁷¹¹ *ibid.*

¹⁷¹² CESCR, ‘*General Comment No. 14*’ UN Doc E/C.12/2000/4 (n 406) para 33.

¹⁷¹³ UNGA, ‘Report of the Special Rapporteur on the Right of Everyone to the Enjoyment’ (n 409) para 15.

The current international human rights law framework still relies on a state-centric approach to human rights. Furthermore, according to the positivist view of international law, only states are subjects of international law, and non-state actors, such as corporations, are classified as objects, thus lacking international legal personality.¹⁷¹⁴ International legal personality is considered a prerequisite for bearing international rights and duties. The ICJ defines legal personality as “being capable of possessing international human rights and duties, and that has the capacity to maintain its rights by bringing international claim” and emphasizes that “subjects of law in any legal system are not necessarily identical in their nature or in the extent of their rights”.¹⁷¹⁵

As JÄGERS explains, corporations are international legal persons since they fulfill the elements of the ICJ definition, and therefore they are capable of possessing international human rights obligations.¹⁷¹⁶ In addition, the author emphasizes that acknowledging that corporations have legal personality does not mean that States are not the primary bearers of duties in international human rights law.¹⁷¹⁷ Thereby, the corporation’s obligation exists in addition to the obligations of States. Finally, she refers that the nature of human rights and the general provision in the International Bill of Rights, such as the preamble of UDHR support the idea that human rights can be applied in horizontal relations.¹⁷¹⁸

Moreover, NOWROT argues that currently corporations have economic and political power, representing an influential role in the international system, and thus they can contribute to and negatively affect the promotion and protection of public goods.¹⁷¹⁹ Thus, it can be acknowledged that, in fact, corporations have legal capacity and, as such, should carry international human rights obligations.

BILCHITZ understands that corporations are bound by key international human rights instruments, and that human rights entail duties upon those who have the capacity to violate them or assist in their realization. Therefore, it is incoherent to root the responsibilities of corporations in social expectations. Moreover, he raises the question of how to determine these

¹⁷¹⁴ Ludovica Chiussi Curzi, *General Principles for Business and Human Rights in International Law* (Brill | Nijhoff, 2020) 287.

¹⁷¹⁵ ICJ, *Reparation for Injuries Suffered in the Service of the United Nations (Advisory Opinion)* [1949] ICJ Rep 174, 178.

¹⁷¹⁶ Jägers, *Corporate Human Rights Obligations: In Search of Accountability* (n 444) 34-35.

¹⁷¹⁷ *ibid.*

¹⁷¹⁸ *ibid.*, 45.

¹⁷¹⁹ Karsten Nowrot, ‘Reconceptualising International Legal Personality of Influential Non-State Actors: Towards a Rebuttable Presumption of Normative Responsibilities’ in Fleur Johns (ed), *International Legal Personality* (Routledge 2017).

social expectations and how they can differ depending on the context. Following the examples he gives, it can be argued that in the globalized world where multinational food corporations have large amounts of wealth and power, the “status quo” is to socially accept all the practices they have been doing for years to promote unhealthy products and undermining the right to access to nutritious food and the right to health.

In addition, “doing no harm” is considered a negative responsibility rather than a positive responsibility to achieve the realization of human rights. The argument that imposing some positive obligations on corporations would undermine the State’s obligation should not thrive. Conversely, doing so can potentially assist States in realizing their own obligations and even corroborate with the basis of the framework, which is founded upon the idea of “differentiated but complementary responsibilities.” Finally, as BILCHITZ emphasizes, “having an obligation to contribute towards the realization of rights is not equivalent to placing the whole responsibility upon one agent.” Thus, in the context of NCD prevention, it is unequivocal that States still have the tripartite obligation towards the right to health and the right to adequate food. At the same time, recognizing food corporations’ duties would assist in achieving the fundamental rights described here.

Moreover, in the context of human rights due diligence, corporations must actively work to prevent causing harm.¹⁷²⁰ The concept of mandatory human rights due diligence has been explored in relation to multinational food corporations and their role in childhood obesity.¹⁷²¹ BARTLETT has advocated for a compulsory right to health due diligence as a balanced approach to address two key concerns: avoiding the imposition of direct human rights obligations on food corporations while ensuring they are adequately held accountable for practices contributing to obesogenic environments.¹⁷²²

4.2 Human rights obligation of private actors

It is unequivocal that the actions of transnational companies have significant impacts on society. Multinational food corporations promote legal but unhealthy products. Ultra-processed food, fast food, and sweetened beverages are legal products that result from a legit economic activity.

¹⁷²⁰ John Ruggie, ‘Protect, Respect and Remedy: A Framework for Business and Human Rights’ UN Doc A/HRC/8/5 (7 April 2008) para 55.

¹⁷²¹ Oliver Bartlett, ‘Multinational Food Corporations and the Right to Health: Achieving Accountability through Mandatory Human Rights Due Diligence?’ in Amandine Garde, Joshua Curtis and Olivier De Schutter (eds), *Ending Childhood Obesity* (Elgar Studies in Health and the Law 2020).

¹⁷²² *ibid.*

Nevertheless, those products are dangerous to human health and the corporation's actions to promote these products negatively impact the right to health and the right to adequate food globally.

In addition, one must recognize that corporations enjoy extensive rights under international investment and trade law. There is an inherent conflict between two orders of rights: the human rights of individuals and the economic/commercial rights of corporations. And in the current system, the commercial rights of corporations have been granted with primary significance over the human rights of individuals, in this case, the right to health and the right to adequate food. Thus, the combination of great power without great accountability has gained attention in the field of business and human rights.

One argument to support the recognition of the obligation of private parties towards human rights is that “human rights are not uni-relational,” meaning that “all individuals have these inherent rights based on the idea of human dignity”.¹⁷²³

As BILCHITZ argues, there is a significant lacuna at the international level in recognizing the potential role of business in contributing to addressing important challenges such as global poverty and environmental sustainability.¹⁷²⁴ This is extended to the prevention of non-communicable diseases scenario and the role of ultra-processed food corporations in changing the food systems to improve global health and consequently for sustainable development. Thereby, acknowledging that multinational food corporations have more than a mere responsibility to respect human rights but rather an extensive obligation towards the right to health and the right to adequate food will advance meeting one of the most forgotten global challenges of our time: the “silent pandemic of non-communicable disease”.¹⁷²⁵

Thus, in the case of PPPs for NCD prevention, a business and human rights framework is crucial. In this framework, incorporating due diligence obligations for private actors concerning the right to health and adequate food in PPPs for NCD prevention could be a tool to advance public health objectives. Nonetheless, it is important to highlight that recognizing the obligation

¹⁷²³ Surya Deva, ‘Business and Human Rights: Time to Move beyond the “Present”?’ in César Rodríguez-Garavito (ed), *Business and Human Rights* (Cambridge University Press 2017).

¹⁷²⁴ David Bilchitz and Surya Deva, ‘The human rights obligations of business: a critical framework for the future’ in Surya Deva and David Bilchitz (eds), *Human Rights Obligations of Business: Beyond the Corporate Responsibility to Respect?* (Cambridge University Press, 2013) 1-26.

¹⁷²⁵ Bryk Silveira, ‘Risk-Creating Industries’ Obligation to the Right to Health’ (n 1707).

to human rights does not mean the delegation of public functions (in this case, allowing private actors to decide about public health objectives).

5 Environmental voluntary agreements

Another example that can help to develop a more comprehensive framework can be drawn from environmental voluntary agreements. In these agreements, firms voluntarily commit to specific environmental initiatives, while regulators oversee, encourage, and can supervise these efforts. Arguments in favor of these types of collaborations are that they offer regulators an alternative to traditional command-and-control approaches, allowing for more flexible, cost-effective environmental protection.¹⁷²⁶ For companies, it reduces regulatory burdens, strengthens their environmental competencies, and communicates their commitment to sustainability to the population.¹⁷²⁷ Environmental voluntary agreements have been utilized as a strategy in the United States and the European Union.¹⁷²⁸

There are significant parallels between industries that contribute to climate change and the food industry, and here another one is added: the way these sectors are regulated (or, more precisely, the lack of regulation and the industry argument of alternative regulatory approaches). It can be highlighted that the arguments in favor (more flexible than command-and-control regulations, the advantages for companies) of this approach relate to the idea of PPPs for NCD prevention.

In the environmental scenario, these voluntary agreements with the private sector can also take various forms and have different objectives. The two main categories are negotiated agreements and public voluntary programs. In negotiated agreements, firms and regulatory agencies negotiate specific environmental performance targets that firms must meet.¹⁷²⁹ Conversely, public voluntary programs involve regulators setting the framework and establishing basic requirements for participation. Firms that join these programs typically commit to pollution reduction targets that exceed regulatory mandates. In return, regulatory bodies may provide research and development subsidies, technical assistance, or help enhance the firm's

¹⁷²⁶ Magali A Delmas and Ann K Terlaak, 'A Framework for Analyzing Environmental Voluntary Agreements' (2001) 43 California Management Review 44.

¹⁷²⁷ *ibid.*

¹⁷²⁸ *ibid.*

¹⁷²⁹ *ibid.*

environmental reputation. These programs complement existing regulations, which remain in place.¹⁷³⁰

However, studies over the years have shown that voluntary agreements are not always the most effective means of addressing environmental issues. Public Voluntary Programs, for example, often rely on non-binding memoranda of understanding, where participants commit to environmental goals but face no penalties for withdrawal or failure to meet those targets.¹⁷³¹ Finally, the threat to legislation has been identified as an incentive for companies to fulfill their commitments.¹⁷³²

6 Social Impact Bonds

A few alternative solutions have been developed for NCD prevention, including the private sector, which has similarities and differences with PPPs for NCD prevention. Some key characteristics of these alternative tools could be applied to PPPs for NCD prevention to enhance their effectiveness in achieving public health outcomes.

An innovative initiative to finance projects where funding is not tied to specific activities and outputs, but to the outcomes it is aiming to deliver, is the Social Impact Bonds (SIBs). Under this model, various investors contribute initial capital to launch a program. The government reimburses the investors with interest if the program achieves specified success metrics.¹⁷³³ The idea of performance is crucial in this model; therefore, if the intermediary fails to reach the minimum performance target, the government does not pay.¹⁷³⁴ First, introduced in 2010 to finance a prisoner rehabilitation project in Peterborough Prison in the UK.¹⁷³⁵ SIBs have expanded across different jurisdictions and areas.

In the United States, the concept associated with SIBs is commonly referred to as “Pay for Success,” which serves as a general term for outcome-based contracting, where a public entity

¹⁷³⁰ *ibid.*

¹⁷³¹ Dinah A Koehler, ‘The Effectiveness of Voluntary Environmental Programs-A Policy at a Crossroads?’ (2007) 35 *Policy Studies Journal* 689.

¹⁷³² Anna Bryden and others, ‘Voluntary Agreements between Government and Business — a Scoping Review of the Literature with Specific Reference to the Public Health Responsibility Deal’ (2013) 110 *Health Policy* 186.

¹⁷³³ Amy S Katz and others, ‘Social Impact Bonds as a Funding Method for Health and Social Programs: Potential Areas of Concern’ (2018) 108 *American Journal of Public Health* 210.

¹⁷³⁴ Hanna Azemati and others, ‘Social Impact Bonds: Lessons Learned so Far’ [2013] *Community Development Innovation Review* 23.

¹⁷³⁵ Social Finance, ‘Impact Bonds’ (*Social Finance*) <<https://www.socialfinance.org.uk/what-we-do/social-impact-bonds>> accessed 27 November 2024.

enters into an agreement with a nonprofit or private service provider. Payment is contingent on the provider achieving specified results.¹⁷³⁶ Unlike traditional public-sector programs, providers under “Pay for Success” agreements do not receive upfront funding from the public entity. Instead, private investors supply the initial capital, assuming the financial risk if the provider fails to meet the agreed outcomes and thus forfeits payment. While “Pay for Success” broadly encompasses outcome-based contracting, SIBs represent a specific financial mechanism used to fund “Pay for Success” contracts.¹⁷³⁷

The first SIB for health was launched in the United States in 2013 (by Social Finance USA and Collective Health) and financed interventions to reduce chronic asthma in low-income children in California.¹⁷³⁸ From there, a few other initiatives were launched in the health arena. For instance, in 2016, Canada’s Community Hypertension Prevention Initiative SIB to prevent cardiovascular disease, which involved an online health learning platform with support from dietitians and personal health coaches, membership to health and fitness centers, and optimum points (for groceries, retail, gas) to incentivize and reward healthy behaviors.¹⁷³⁹ In the same year, Israel developed a SIB initiative to prevent type 2 diabetes, which also used education on behavioral and lifestyle changes through exercise, diet, nutrition, and motivation.¹⁷⁴⁰

One defining characteristic of SIBs is their reliance on clearly specified target outcomes.¹⁷⁴¹ Additionally, proponents argue that SIBs enhance accountability because their evaluation is based on predetermined metrics, and investor payouts are contingent on achieving measurable results.¹⁷⁴²

Finally, a common justification for using SIBs is that the public sector lacks the resources and flexibility to address complex social challenges effectively. Partnering with the private sector is seen as a way to achieve positive outcomes and sustain impactful interventions. This shared rationale of public sector failures highlights a common thread between SIBs and PPPs.

¹⁷³⁶ Omar Carrillo, ‘Pay for Success: Opportunities and Challenges in Housing and Economic Development’ (JCHS 2017).

¹⁷³⁷ *ibid.*

¹⁷³⁸ Emily Susannah Grace Hulse and others, ‘Use of Social Impact Bonds in Financing Health Systems Responses to Non-Communicable Diseases: Scoping Review’ (2021) 6 *BMJ Global Health*.

¹⁷³⁹ *ibid.*

¹⁷⁴⁰ *ibid.*

¹⁷⁴¹ Samantha Iovan and Paula M Lantz, ‘Social Impact Bonds: A Promising Public–Private Partnership Model for Public Health’ (2018) 108 *American Journal of Public Health*.

¹⁷⁴² *ibid.*

One argument in favor of SIBs is that many SIBs are implemented under legislation that safeguards existing government programs or services from being replaced.¹⁷⁴³ Currently, the UK and the US have passed legislation to support SIBs. For instance, in the US, the state of Massachusetts passed legislation to permit Pay-for-Success agreements.¹⁷⁴⁴

However, the dynamics of Social Impact Bonds, being financial agreements, differ significantly from traditional PPPs for NCD prevention. For instance, consider voluntary agreements for product reformulation. How might these align with the SIB model? Under such a framework, companies would need to achieve specific reformulation targets to qualify for financial payouts. This raises significant concerns about whether offering financial incentives to already economically powerful corporations genuinely advance NCD prevention goals. Nevertheless, the potential of SIBs in areas such as diabetes prevention is worth exploring, even though the available data on their effectiveness remains limited. Thus, here, the most important idea would be to collect the elements of specific target outcomes, which, in the case of discussion, would be a reduction of the amount of sugar/salt in the ultra-processed products.

To date, there is limited data on the long-term effects and overall effectiveness of SIBs in addressing non-communicable diseases. It has been identified that only three of the seven SIBs utilized for financing NCD initiatives have successfully met all their target outcomes.¹⁷⁴⁵ The primary issues identified include conflicts of interest and a lack of public transparency.¹⁷⁴⁶ Moreover, a key criticism that can be identified is that these initiatives place emphasis on personal responsibility, as observed in the SIBs implemented in Israel and Canada, which focused primarily on educational interventions. And finally, the idea of conflict of interest persists.

7 Formal contract

¹⁷⁴³ *ibid.*

¹⁷⁴⁴ Emily Gustafsson-Wright, Sophie Gardiner and Vidya Putcha, 'The Potential and Limitations of Impact Bonds: Lessons from the First Five Years of Experience Worldwide' (*Brookings* 2015) <<https://www.brookings.edu/articles/the-potential-and-limitations-of-impact-bonds-lessons-from-the-first-five-years-of-experience-worldwide/>> accessed 7 July 2025.

¹⁷⁴⁵ Hulse and others, 'Use of Social Impact Bonds in Financing Health Systems Responses to Non-Communicable Diseases' (n 1738).

¹⁷⁴⁶ *ibid.*

7.1 Preliminary remarks

In traditional PPP arrangements, a formal contract (often a public contract) is signed by all parties, clearly specifying the terms of the agreement and setting measurable deliverable targets. The agreement also includes mechanisms to manage risks and enforce compliance if targets are not met. Nevertheless, this component is not present in PPPs for NCD prevention. Thus, this model could be adapted to voluntary agreements with the food industry, particularly for the reformulation of unhealthy products.

PPPs for NCD prevention should be structured within a clear contractual framework: an agreement that explicitly delineates the roles and responsibilities of each party, establishes measurable targets, sets out concrete plans for achieving these objectives, and incorporates robust monitoring mechanisms to ensure compliance and evaluate progress.

7.2 Key elements

Building on principles of accountability and transparency, as well as insights from UN guidance, the public health literature, the business and human rights framework, social impact bonds, and environmental voluntary agreements, the contract should incorporate several key elements.

First, the contract should establish government-determined targets, free from undue private sector influence. Scientific evidence shows the importance of clear and specific targets (this includes quantifiable targets with time frames and a specified baseline).¹⁷⁴⁷ This idea can be supported by the case studies presented; vague or overly broad targets, such as those in the Responsibility Deal, can lead to ineffectiveness, while more precisely defined goals, as seen in the Whole Grain Partnership, have resulted in better outcomes. In addition, not granting the private sector the role in deciding the targets is a measure to prevent COI.

A written agreement should be signed by high-ranking public authorities to emphasize the seriousness of the commitment and collaboration. For example, in the Declaration of Milan, the Federal Council signed the agreement, demonstrating strong governmental commitment.¹⁷⁴⁸ Similarly, representatives at the highest levels of the food industry, such as CEO's, should be the ones signing the contract to ensure accountability.

¹⁷⁴⁷ Bryden and others, 'Voluntary Agreements between Government and Business' (n 1732).

¹⁷⁴⁸ However, in this case there is a lack of authority oversight. See Part 4, Chapter 12, I, 3.

Measurable targets are key. For example, ingredient reduction goals should be established for specific product categories, such as yogurts, biscuits, sweetened beverages, and dairy drinks, to make the objectives more precise, achievable, and comparable. The Declaration of Milan set specific targets for different categories of sugary products; the US Voluntary Sodium Reduction Goals have similarly defined clear and measurable goals. Establishing such concrete targets can enhance the accountability of PPPs in NCD prevention. Concerns about the scientific standard setting of these targets remain.¹⁷⁴⁹ Thus, PPPs for NCD prevention should incorporate reformulation targets grounded in robust scientific standards that reflect what is demonstrably beneficial for public health and nutrition. Industry should not influence the target setting (again keeping the idea of preventing COI).

A key question arises: Why would companies participate in such agreements? The answer lies in embedding enforceable consequences for non-compliance. If companies fail to meet agreed-upon targets within a specified timeframe, they could face the imposition of stricter command-and-control regulations, such as sweetened beverage taxes or mandatory front-of-package labeling. For instance, in environmental voluntary agreements, where there is a threat of legislation, companies fulfill their commitments.¹⁷⁵⁰ Thus, sanctions for non-compliance are crucial elements that must be present in this formal agreement. It is beyond the scope of this research to analyze competition law clauses that may arise from the adoption of taxes on a specific category of product.

Another point to enhance participation is the influence of public image. Studies indicate that public image serves as a benefit and a potential sanction.¹⁷⁵¹ For example, when voluntary schemes are highly visible to the public and are strongly promoted, participation rates tend to increase. Public image can thus be leveraged to encourage compliance.¹⁷⁵²

From another perspective, public image can be used against the industry. This relates to the principle of transparency and the idea of “naming and shaming” exposed by REEVE and MAGNUSSON. In the same vein, “regulatory shaming”, extensively explored by YADIN, can be adapted to non-regulatory spaces, such as voluntary agreements.

YADIN notes that “unlike civilian shaming, regulatory shaming is subject to public law norms; it does not aim to humiliate or hurt individuals’ feelings but to inflict reputational harm on

¹⁷⁴⁹ Part 3, Chapter 10, II.

¹⁷⁵⁰ Bryden and others, ‘Voluntary Agreements between Government and Business’ (n 1732).

¹⁷⁵¹ *ibid.*

¹⁷⁵² *ibid.*

business organizations and nudge them in the right direction”.¹⁷⁵³ YADIN emphasizes that regulatory shaming is “meant to enforce norms without relying solely on “command and control”.¹⁷⁵⁴ Applying this mechanism to compliance with labeling regulations in Israel, she highlights how shaming tactics can motivate companies to fully adhere to new and existing regulatory reforms.¹⁷⁵⁵ While PPPs operate in a non-regulated space, shaming, with appropriate adaptations, can still be an effective tool. By leveraging its impact on public image, companies may be motivated to meet agreed-upon targets.

Another key element in the effective implementation of PPPs for NCD prevention is the need for robust monitoring mechanisms. Most of the examples often lack sufficient mechanisms for closely tracking progress toward targets. However, robust monitoring is essential to ensure accountability and verify compliance with established goals. Additionally, it is important to have neutral and independent review monitoring, which means that in these cases, it should not be done by the industry but by an independent third party to guarantee transparency. Thus, to address this, formal written agreements should include clearly defined timelines for regular evaluations. For example, these agreements could mandate an independent external review (important for mitigating conflicts of interest), on an annual/semester basis to assess progress. Such evaluations should answer key questions: Are the targets being met? If not, why? How significant is the gap? How far are they?

The findings of these reviews could then be published to enhance transparency and leverage public accountability. Public disclosure, potentially incorporating elements of “naming and shaming”, might generate societal and stakeholder pressure, prompting improved compliance or the adoption of stricter regulations where necessary.

Additionally, formal agreements must establish enforcement mechanisms to address non-compliance. For instance, initiatives like the US Voluntary Sodium Reduction Goals or the Declaration of Milan have successfully incorporated clear objectives with measurable, defined targets (although concerns can be raised about the scientific standard setting). However, both suffer from notable deficiencies in monitoring, compliance enforcement, and addressing the consequences of failing to meet goals. Despite repeatedly missing their original targets, these initiatives have been renewed without adopting stricter regulatory frameworks or implementing

¹⁷⁵³ Sharon Yadin, ‘Shaming Big Pharma’ (*Yale Journal on Regulation* 2019) <<https://www.yalejreg.com/bulletin/shaming-big-pharma/>> accessed 3 June 2025.

¹⁷⁵⁴ *ibid.*

¹⁷⁵⁵ Sharon Yadin, ‘Manipulating Disclosure: Creative Compliance in the Israeli Food Industry’ (2021) 66 *Saint Louis University Law Journal* <<https://scholarship.law.slu.edu/lj/vol66/iss1/9>> accessed 4 July 2025.

enhanced compliance mechanisms. Such shortcomings underscore the need for robust formal contractual agreements to prioritize accountability and enforceability.

Finally, the importance of meaningful sanctions for non-compliance. As highlighted in the case studies, meaningful sanctions are absent, and even if there is a provision for them, they are rarely seen in practice. As pointed out, this factor is one of the weaknesses in voluntary schemes.¹⁷⁵⁶ Thus, an additional element to be implemented is the idea of the “right to terminate the partnership” or “contract cancellation/termination.”

As shown, traditional PPPs often include termination clauses that address “default by the private party”, typically referring to the “failure to complete construction” or a “persistent failure to meet performance standards”.¹⁷⁵⁷ Thus, it could be included in PPPs for NCD prevention, a provision for contract termination, meaning if the private party fails to meet the intended public health objectives (such as reducing sugar content in specific products), the contract will be terminated, and stricter regulation would be adopted. This approach also aligns with the “right to terminate partnership” stipulated in the FAO’s Strategy for private sector engagement 2021-2025.¹⁷⁵⁸

Finally, the State’s duty of oversight becomes even more pronounced. Under the business and human rights framework, UN Guiding Principle 5 establishes that when States contract with, or regulate, business enterprises to provide services that may affect human rights, they are required to exercise adequate oversight to ensure compliance with their human rights obligations.¹⁷⁵⁹ It is clear that the impact of the multinational food corporations on the enjoyment of the right to health and the right to adequate food.¹⁷⁶⁰ Thus, States have to implement mechanisms to exercise oversight to ensure that the targets are being met.

With a formal contractual agreement, PPPs can serve as an alternative tool to traditional regulation, functioning as a form of quasi-regulation and no co-regulation. This means the government continues to influence the development and implementation of self-regulatory initiatives. Crucially, the core public functions (public health of the population) are not delegated to the industry, preserving the state’s primary responsibility for public health.

¹⁷⁵⁶ Belinda Reeve and Roger Magnusson, ‘Reducing Unhealthy Food and Beverage Advertising to Children: A Framework for Strengthening Performance, Transparency and Enforcement’ (2024) 1 *Journal of Global Health Law* 229.

¹⁷⁵⁷ See Part 3, Chapter 10, II, 4.

¹⁷⁵⁸ See Part 4, Chapter 13, II, 1.

¹⁷⁵⁹ Guiding principle 5 of UNGPs, See also the analysis in PPPs in general, Part 3, Chapter 9, II, 4.

¹⁷⁶⁰ Bryk Silveira, ‘Risk-Creating Industries’ Obligation to the Right to Health’ (n 1707).

7.3 Applying the contractual framework to the Swiss context: Declaration of Milan

Within the examples of PPPs for NCD prevention presented,¹⁷⁶¹ a practical application of this contractual framework can be translated to the ongoing Declaration of Milan in Switzerland.

The Declaration of Milan is based on a written agreement signed by high-ranking authorities, thus already satisfying essential elements outlined here. However, authority oversight is lacking. This shows that it is not enough to be agreed upon by high-ranking authorities. Oversight mechanisms have to be in place. Initially, it did not set measurable targets, but this was solved in the version adopted in 2017. As such, this example features a written agreement with measurable targets and even incorporates the concept of a “right to terminate the partnership”.

However, this model also exposes several shortcomings. First, it lacks transparency, which undermines accountability. Second, there is a concern regarding the scientific standards applied, as industry involvement in setting the targets allows corporate interests to potentially outweigh public health objectives. To safeguard against this and manage conflict of interest concerns, targets should be determined by the government, ensuring they are guided by public health priorities rather than industry influence.

Moreover, the agreement does not specify details of how the monitoring mechanisms operate, underscoring the need for government oversight, which is notably lacking in this case.

Finally, fails to implement enforceable consequences. If companies do not meet the agreed objectives, there are no compliance measures or sanctions. This is precisely where the concept of contract cancellation or termination of the partnership becomes relevant. In such cases, a stricter regulatory approach to NCD prevention should be considered.

II Conclusion

PPPs for NCD prevention are an alternative tool to stricter regulation used by many countries and encouraged by international organizations. The main argument in favor of partnering with industry is the belief that it is more effective than operating independently of them, and at least there is an action to drive improvements.¹⁷⁶² Within this framework, this part aimed to establish

¹⁷⁶¹ See Part 3, Chapter 10, II Case studies: public-private partnerships with ultra-processed food and the sweetened beverage industries.

¹⁷⁶² Panjwani and Caraher, ‘The Public Health Responsibility Deal’ (n 1302).

clear boundaries for food industry involvement in PPPs aimed at product reformulation. Product reformulation has the perceived advantage of using the expertise of these industries on their unhealthy products. Collaborations of this nature might contribute to advancing public health goals and addressing non-communicable diseases, if properly structured.

At the international level, documents providing guidance to “private sector engagement agreements” highlight the importance of respecting the role and mission of the relevant UN agency in question. These agreements stress the importance of aligning industry actions with the agency’s objectives. At the domestic level, PPPs for NCD prevention frequently lack similar detailed guidance. For example, they often fail to incorporate human rights principles or to articulate the justification for such partnerships.

Moreover, robust monitoring systems are also indispensable. Independent and transparent oversight mechanisms should be embedded in the structure of PPPs to ensure credibility and foster trust. Periodic reviews, conducted semi-annually or annually, are essential for assessing progress and addressing shortcomings. External, independent evaluations play a crucial role in this process, offering an objective perspective on whether the partnership is meeting its goals.

Human rights principles, particularly accountability and transparency, must serve as foundational elements of these partnerships. Accountability involves evaluating the partnership’s functioning and ensuring that consequences are enforced if objectives are not met.

In addition, the “right to terminate the partnership”, as seen in the FAO strategy, provides a valuable precedent. This idea is also present in the original format of PPPs. Thus, when the private sector does not deliver the result, the State can terminate the partnership for NCD prevention and add the idea of enforcing stricter regulation if the targets are not met.

Finally, formal written contracts such as those in PPPs in general must be established even in the context of voluntary agreements and non-binding arrangements. These contracts should include clear compliance mechanisms and defined consequences for non-compliance to ensure the achievement of desired outcomes.

In conclusion, the overarching objective of improving public health must remain paramount. In PPPs for NCD prevention, States continue to have the obligation to the right to health. Thus, if States opt for this alternative regulatory tool as a strategy for NCD prevention, this obligation remains. Achieving this goal requires the implementation of robust contractual agreements with clear accountability frameworks, authority oversight, and transparent monitoring systems.

CHAPTER 13: DENORMALIZING PPPs AS A REGULATORY TOOL FOR NCD PREVENTION

I Preliminary remarks

This second hypothesis recognizes the failure of PPPs as an alternative regulatory approach for NCD prevention. As demonstrated in the scientific evidence, in the literature, and case studies, the inherent conflicts of interest within the food industry undermine public health objectives, defying these collaborations' normative purpose. Moreover, scholars have also been against the establishment of PPPs for NCD Prevention. GODZIEWSKI and FOOKS understand that “partnership constitutes a rejection of government-led, evidence-based, population-level approaches to managing the market environment for food and beverages in favor of non-evidenced based strategies in which government responsibility for population nutrition is displaced onto epidemiologically compromised corporation”.¹⁷⁶³ Moreover, GARDE underscored “public–private partnerships with the food and alcohol industries have inherent limits”.¹⁷⁶⁴

Nonetheless, the critical concern remains: multinational food corporations continue to be regarded as legitimate partners in public health and receive a distinctive legal approach from industries such as tobacco, despite their comparable role in driving NCDs.

A study found that over a quarter of health advocates and policymakers expressed challenges in forming a definitive position on the food and beverage sector because of the essential nature of food, which distinguishes it from tobacco and alcohol, as well as the encompassing beneficial and harmful products at the same time.¹⁷⁶⁵ Nevertheless, a growing body of evidence indicates that these industries are employing strategies similar to those historically used by Big Tobacco to weaken public health initiatives.¹⁷⁶⁶

Adding importance for this comparison, is relevant to point out that in the 1980s, tobacco giants Philip Morris and R.J. Reynolds acquired major food companies such as Kraft, General Foods and Nabisco, allowing tobacco firms to dominate America's food supply and generate billions

¹⁷⁶³ Fooks and Godziewski, ‘The World Health Organization, Corporate Power, and the Prevention and Management of Conflicts of Interest in Nutrition Policy Comment’ (n 1570).

¹⁷⁶⁴ Garde, ‘The Lack of Coherence in the European Union's Approach to Noncommunicable Disease Prevention’ (n 653).

¹⁷⁶⁵ Jeff Collin and others, ‘Can Public Health Reconcile Profits and Pandemics? An Analysis of Attitudes to Commercial Sector Engagement in Health Policy and Research’ (2017) 12 PLOS One.

¹⁷⁶⁶ Brownell and Warner, ‘The Perils of Ignoring History’ (n 30).

in sales from popular brands such as Oreo cookies, Kraft Macaroni & Cheese and Lunchables.¹⁷⁶⁷ Increasing evidence has also linked the parallels of addiction to the rise of “hyper-palatable” foods, products engineered with potent combinations of fat, sugar, sodium, and additives that drive cravings and overconsumption.¹⁷⁶⁸

As GOSTIN and WILEY observe, “law is a reinforcing expression of social norms”.¹⁷⁶⁹ They argue that unhealthy consumption patterns, actively promoted by profit-driven manufacturers and retailers, significantly burden public health and diminish quality of life. They further identify the denormalization of unhealthy products as a promising strategy to address these challenges.¹⁷⁷⁰

However, first, there is a pressing need to denormalize the legal treatment of the food industry within the broader legal framework governing NCDs. Taking the regulatory approach toward the tobacco industry at the international level as an analogous example, this hypothesis understands the exclusion of food industry actors from direct involvement in public health initiatives due to their potential to undermine policy efforts. Then, it presents at the domestic level legal tools that can be used to advance the “denormalization” of unhealthy products.

II Social denormalization through regulation

The similarities between the tobacco industry’s and food industry’s practices have been extensively discussed.¹⁷⁷¹ Furthermore, the complexity of addiction to ultra-processed foods adds an additional layer to this comparison.¹⁷⁷² Scientific research has repeatedly highlighted these similarities, raising strong arguments against the food industry’s involvement in public-private partnerships for the prevention of non-communicable diseases. Despite this, the current

¹⁷⁶⁷ Anahad O’Connor, ‘Many of Today’s Unhealthy Foods Were Brought to You by Big Tobacco’ (*Washington Post*, 2023) <<https://www.washingtonpost.com/wellness/2023/09/19/addiction-foods-hyperpalatable-tobacco/>> accessed 28 June 2025.

¹⁷⁶⁸ Michael Moss, *Hooked: Food, Free Will, and How the Food Giants Exploit Our Addictions* (Signal 2022); Tera L Fazzino and others, ‘US Tobacco Companies Selectively Disseminated Hyper-Palatable Foods into the US Food System: Empirical Evidence and Current Implications’ (2023) 119 *Addiction*.

¹⁷⁶⁹ Gostin and Wiley, *Public Health Law: Power, Duty, Restraint* (n 353) 476.

¹⁷⁷⁰ *ibid.*

¹⁷⁷¹ Stuckler and Nestle, ‘Big Food, Food Systems, and Global Health’ (n 28); Brownell and Warner, ‘The Perils of Ignoring History’ (n 30); Sarah A Raoche and others, ‘Big Food and Soda versus Public Health: Industry Litigation against Local Government Regulations to Promote Healthy Diets’ [2018] *Georgetown Law Journal*; Mialon, ‘An Overview of the Commercial Determinants of Health’ (n 326); Viroj Tangcharoensathien and others, ‘Addressing NCDs: Challenges from Industry Market Promotion and Interferences’ (2019) 8 *International Journal of Health Policy and Management* 256; Marmot and Bell, ‘Social Determinants and Non-Communicable Diseases’ (n 245); Nestle, *Food Politics: How the Food Industry Influences Nutrition and Health* (n 1583).

¹⁷⁷² Moss, *Hooked: Food, Free Will, and How the Food Giants Exploit Our Addictions* (n 1768).

international legal framework does not exclude the food industry from public health policy-making, instead encourage the establishment of PPPs for NCD prevention.

This final section pushes back against the current norm and the idea of using PPPs for NCD prevention as an alternative regulatory tool. In this case, if PPPs are dismissed as an alternative regulatory approach, the regulatory response must rely on traditional command-and-control measures to achieve public health objectives.¹⁷⁷³ It applies the denormalization theory to argue for the exclusion of food industry actors from the public health decision-making arena. Not long ago, tobacco use was considered “normal” and embedded in everyday life. It was once unremarkable to smoke on airplanes, and the tobacco industry had a legitimate seat at the policymaking table. Today, such scenarios are almost unimaginable, demonstrating how social norms can shift dramatically. Drawing from this precedent, this section explores how similar strategies might be employed to reshape the food industry’s role in public health and calls on States to fulfill their human rights obligation towards the realization of the right to health.

1 Normalization and denormalization theory

The normalization theory originated in the UK in the mid-1990s with a focus on illicit drug consumption. A team of researchers developed a theoretical framework to explain how the use of certain illicit drugs, specifically cannabis, nitrates, amphetamines, and, to a lesser extent, ecstasy, had become “normalized”.¹⁷⁷⁴ According to this theory, the recreational use of these substances has become a routine aspect of life for some young people, particularly in the context of leisure and pleasure-seeking activities. They also argued that drug use had gained social and cultural acceptance among segments of the non-using population and had become increasingly integrated into broader societal norms.¹⁷⁷⁵

The normalization theory has been used from a public health perspective regarding illicit drugs. For instance, the normalization of cannabis (although controversial) has been safeguarded by public health arguments. Regarding tobacco and unhealthy food, the argument from a public health perspective is to denormalize.

¹⁷⁷³ See the different regulatory approaches in Public Health Law in Part 1, Chapter 3, II, 2 Regulatory approaches.

¹⁷⁷⁴ Howard J Parker, Judith Aldridge and Fiona Measham, *Illegal Leisure: The Normalization of Adolescent Recreational Drug Use* (Routledge 1998).

¹⁷⁷⁵ *ibid.*

Building on this framework, the concept of “denormalization” was developed. Denormalization refers to a social structural process through which a particular activity or object is increasingly perceived as “undesirable, unwanted, or socially unacceptable”.¹⁷⁷⁶ The purpose of denormalization is to challenge a behavior’s legitimacy, position it as neither normal nor mainstream, and encourage individuals and society to abandon participation in it.¹⁷⁷⁷ This process also educates the public and generates support for policies and interventions designed to shape behavior in alignment with these values.¹⁷⁷⁸ Denormalization has been applied to domains such as alcohol and tobacco consumption. WILEY has extended the theory to the context of unhealthy food.¹⁷⁷⁹

The argument for a socially acceptable image of smoking has been one of the central strategies of the tobacco industry’s marketing strategies, particularly focusing on young people.¹⁷⁸⁰ In the first half of the twentieth century, tobacco was a normalized behavior and perceived as a desirable commodity among the social elite.¹⁷⁸¹

The denormalization of smoking involved a deliberate effort to alter societal norms surrounding tobacco use, repositioning it from a socially accepted and desirable behavior to an abnormal and undesirable one.¹⁷⁸² This transformation has been significantly driven by policy measures that restrict smoking in terms of location, timing, and social context.¹⁷⁸³ These policies, combined with robust health advocacy campaigns and media influence, have played a crucial role in reshaping the cultural acceptability of smoking. A key strategy employed by public health advocates has been to frame tobacco product manufacturers as a hazardous and “deadly” industry.¹⁷⁸⁴ Leveraging this narrative, activists worldwide have effectively urged governments to implement stringent tobacco control measures, culminating in landmark achievements such as the adoption of the Framework Convention on Tobacco Control.¹⁷⁸⁵ Art 5.3 of the FCTC can be viewed as a key tool in the global denormalization of the tobacco industry.

¹⁷⁷⁶ Mark Asbridge and others, ‘Normalization and Denormalization in Different Legal Contexts: Comparing Cannabis and Tobacco’ (2016) 23 *Drugs: Education, Prevention and Policy* 212.

¹⁷⁷⁷ *ibid.*

¹⁷⁷⁸ David Hammond and others, ‘Tobacco Denormalization and Industry Beliefs among Smokers from Four Countries’ (2006) 31 *American Journal of Preventive Medicine* 225.

¹⁷⁷⁹ Lindsay F Wiley, ‘Sugary Drinks, Happy Meals, Social Norms, and the Law: The Normative Impact of Product Configuration Bans Response’ (2014) 46 *Connecticut Law Review* 258.

¹⁷⁸⁰ Hammond and others, ‘Tobacco Denormalization and Industry Beliefs’ (n 1778).

¹⁷⁸¹ Asbridge and others, ‘Normalization and Denormalization in Different Legal Contexts’ (n 1776).

¹⁷⁸² Hammond and others, ‘Tobacco Denormalization and Industry Beliefs’ (n 1778).

¹⁷⁸³ Asbridge and others, ‘Normalization and Denormalization in Different Legal Contexts’ (n 1776).

¹⁷⁸⁴ Holly Jarman, ‘Normalizing Tobacco? The Politics of Trade, Investment, and Tobacco Control’ (2019) 97 *The Milbank Quarterly* 449.

¹⁷⁸⁵ *ibid.*

Many countries have adopted comprehensive measures to restrict tobacco use, including bans on smoking in indoor spaces such as offices, shops, public transportation, restaurants, bars, and major outdoor venues. These policies contribute to social denormalization by reducing the visibility of smoking in daily life and diminishing its perception as a regular social activity.¹⁷⁸⁶ However, such measures may also inadvertently lead to stigmatization, as they segregate smokers in public spaces, subjecting them to social scrutiny.¹⁷⁸⁷

Research highlights a strong association between policies and the denormalization of smoking.¹⁷⁸⁸ Social denormalization has been linked to increased awareness of anti-smoking information, exposure to warning labels, and the enforcement of environmental tobacco smoke restrictions. Notably, these restrictions in bars and restaurants appear particularly effective in reshaping beliefs about smoking by disrupting the connection between smoking, drinking, and the “exciting” lifestyles often depicted in tobacco marketing.¹⁷⁸⁹

Moreover, warning labels and anti-smoking media campaigns play a crucial role in shaping social norms by visibly communicating the health risks of smoking to smokers and the general public. The public dissemination of such information has proven to be effective in reducing the perceived acceptability of smoking.¹⁷⁹⁰

Studies have also found that mass media campaigns focusing on the unethical practices of the tobacco industry can be highly effective in promoting denormalization, often surpassing traditional messages targeting social norms and the acceptability of tobacco use.¹⁷⁹¹ Addressing industry tactics rather than solely targeting smokers can reduce the stigma and discrimination associated with tobacco use while achieving positive public health outcomes. The focus on denormalizing the product and the industry offers a more comprehensive approach to combating tobacco use while minimizing the risk of marginalizing smokers.

¹⁷⁸⁶ Lindsay Wiley, ‘Shame, Blame, and the Emerging Law of Obesity Control’ [2013] UC Davis Law Review 121.

¹⁷⁸⁷ Ronald Bayer and Jennifer Stuber, ‘Tobacco Control, Stigma, and Public Health: Rethinking the Relations’ (2006) 96 American Journal of Public Health 47.

¹⁷⁸⁸ Hammond and others, ‘Tobacco Denormalization and Industry Beliefs’ (n 1778).

¹⁷⁸⁹ *ibid.*

¹⁷⁹⁰ *ibid.*

¹⁷⁹¹ *ibid.*

2 Denormalization of Big Food and Big Soda

Although the tobacco and food industries have employed similar strategies to promote their products and protect their interests, there has been far less focus on counteracting the food industry's tactics.¹⁷⁹² Based on the idea of denormalization of the tobacco industry and Art. 5.3 of the FCTC, this part aims to explore the application of denormalization to Big Food and Big Soda, focusing on the industry, its unhealthy products, and its practices. In addition, it includes provisions from the FCFC that helped denormalize tobacco industry strategies that could be applied to tackle the current strategies used by the food industry.

On the idea of denormalization theory, WILEY pointed out that efforts to denormalize obesity have often centered on stigmatizing individuals based on their body size ("fatness") rather than targeting unhealthy products or patterns of overconsumption.¹⁷⁹³ Efforts to denormalize unhealthy food products face unique challenges, partly because an individual's choice of a single meal does not necessarily reflect their overall lifestyle.¹⁷⁹⁴

WILEY argued that the objective should be to denormalize unhealthy food products and consumption behaviors while promoting reasonable portion sizes and balanced eating. This approach would avoid stigmatizing individuals and emphasize public health measures that benefit everyone, regardless of body size or shape.¹⁷⁹⁵

Building on this perspective, the hypothesis advanced here proposes "industry denormalization", in particular "denormalizing" Big Food and Big Soda practices. To prevent the stigmatization of obesity, the focus should be on denormalizing the use of public-private partnerships as tools to legitimize the influence of the food and sweetened beverage industries in the public health scenario. Stricter regulatory measures, rather than voluntary agreements, can emphasize the role of law in shifting social norms and promoting NCD prevention. As already underscored, law can be a powerful vector of socio-economic change.¹⁷⁹⁶

In the public health literature, "denormalizing" the food industry has been identified as "reframing unhealthy products as harmful, portraying corporations' activities as disease

¹⁷⁹² Simon Capewell and Ffion Lloyd-Williams, 'The Role of the Food Industry in Health: Lessons from Tobacco?' (2018) 125 *British Medical Bulletin* 131.

¹⁷⁹³ Wiley, 'Sugary Drinks, Happy Meals, Social Norms, and the Law' (n 1779).

¹⁷⁹⁴ *ibid.*

¹⁷⁹⁵ *ibid.*

¹⁷⁹⁶ Garde, 'Global Health Law and Non-Communicable Disease Prevention' (n 37) 397.

vectors, and highlighting the disingenuous use of the industry's corporate social responsibility programs as brand marketing efforts".¹⁷⁹⁷

2.1 International level

At the international level, Art. 5.3 of the FCTC provides a compelling model.¹⁷⁹⁸ It establishes that parties must act to protect public health policies from the commercial and vested interests of the tobacco industry and rejects the establishment of PPPs.¹⁷⁹⁹ A comparable framework could be adapted to public health policies targeting unhealthy food products. As highlighted throughout this thesis, at the international level, the food industry is not subjected to the same legal treatment as the tobacco industry.

The FCTC was adopted, under Art. 19 of the WHO Constitution.¹⁸⁰⁰ The same legal basis could be applied to adopt a legally binding instrument at the international level concerning unhealthy diets and to limit food corporations' activity. There have been calls in the literature for the adoption of a Global Convention to Protect and Promote Healthy Diets.¹⁸⁰¹

The FCTC is the only international legally binding instrument in the context of NCD prevention.¹⁸⁰² Just as the FCTC drove global change in tobacco control, international action on unhealthy food products and the food industry could make legal and normative pressure that would lead to transformative shifts at the domestic level.¹⁸⁰³ In place of voluntary agreements to salt and sugar reduction, governments should adopt stricter regulations that would have an impact on reformulation. For instance, fiscal measures, such as taxes on sugar-sweetened beverages, have already proven effective in reducing consumption and encouraging product

¹⁷⁹⁷ Laura Nixon and others, "'We're Part of the Solution': Evolution of the Food and Beverage Industry's Framing of Obesity Concerns between 2000 and 2012' (2015) 105 *American Journal of Public Health* 2228.

¹⁷⁹⁸ Jeff Collin, 'Tobacco Control, Global Health Policy and Development: Towards Policy Coherence in Global Governance' (2012) 21 *Tobacco Control* 274.

¹⁷⁹⁹ WHO Framework Convention on Tobacco Control (n 31) art 5.3.

¹⁸⁰⁰ WHO, *Constitution of the World Health Organization* (n 353) art 19.

¹⁸⁰¹ Stefanie Vandevijvere, 'Why a Global Convention to Protect and Promote Healthy Diets Is Timely' (2014) 17 *Public Health Nutrition* 2387.

¹⁸⁰² Part 2, Chapter 5, IV.

¹⁸⁰³ Roger S. Magnusson, 'Global Health Governance and the Challenge of Chronic, Non-Communicable Disease' (2010) 38 *The Journal of Law, Medicine & Ethics* 490.

reformulation to healthier standards.¹⁸⁰⁴ Also, mandatory FOPL has been identified as an effective public health tool that enhances reformulation.¹⁸⁰⁵

The core principle underlying the FCTC is the obligation of States to protect the right to health, an obligation that is equally relevant in the context of food systems. Secondly, the preamble recognizes the negative impact of the tobacco industry on tobacco control efforts.¹⁸⁰⁶

Art.5.3. and its guidelines for implementation recognizes a fundamental and irreconcilable conflict between the tobacco industries and public health policy interests and explicitly reject partnerships and non-binding or non-enforceable agreements with the tobacco industry.¹⁸⁰⁷ Thus recognizing the inherent conflict of interest of food industry in PPPs for NCD prevention, would demark a shift in seeing the food industry as “part of the solution”. With such recognition, the legal treatment of this risk-creating industry will have to undergo some changes also at the domestic level, paving the way for stronger regulations for NCD prevention. Consequently, this could reshape societal consumption patterns of unhealthy products, the same as we have seen with the progress of tobacco control, and considering tobacco “normal”. Many provisions from FCFC could be implemented for the food industry to further progress in denormalizing the unhealthy products from Big Food and Big Soda.

In advocating for corporate accountability of the food industry, Art. 5.3 has been interpreted together with Art. 19 as a mechanism to ensure legal liability.¹⁸⁰⁸ Art. 19 lays down that “control, the Parties shall consider taking legislative action or promoting their existing laws, where necessary, to deal with criminal and civil liability”.¹⁸⁰⁹ This provision reinforces the need for legal mechanisms that hold corporations accountable for health harms linked to their products. In the food sector, there is currently no comparable international framework ensuring corporate liability for the role of ultra-processed food and sugar-sweetened beverages in the NCD epidemic. Introducing similar accountability mechanisms within the food industry would curb harmful commercial practices and reinforce public trust in health governance.

¹⁸⁰⁴ Tatiana Andreyeva and others, ‘Outcomes Following Taxation of Sugar-Sweetened Beverages’ (2022) 5 JAMA Network Open.

¹⁸⁰⁵ Christina A Roberto and others, ‘The Influence of Front-of-Package Nutrition Labeling on Consumer Behavior and Product Reformulation’ (2021) 41 Annual Review of Nutrition 529; Global Health Advocacy Incubator, *Front of Package Labeling – Industry Arguments: Counter-Messages and Evidence* (updated 11 August 2021).

¹⁸⁰⁶ WHO Framework Convention on Tobacco Control (n 31) preamble.

¹⁸⁰⁷ See Part 2, Chapter 5, IV for a detailed analysis.

¹⁸⁰⁸ Daniel Dorado and others, ‘Towards Building Comprehensive Legal Frameworks for Corporate Accountability in Food Governance’ (2021) 64 Development.

¹⁸⁰⁹ WHO Framework Convention on Tobacco Control (n 31) art 19.

The FCTC also provides a broader set of regulatory tools that could be directly transposed to the context of the food industry. For instance, Art. 6 recognizes price and tax measures as effective means to reduce tobacco consumption. Fiscal policies, including sugar taxes and differential taxation for unhealthy food products, have been proposed as essential public health instruments but continue to face resistance.¹⁸¹⁰

Other relevant examples can be drawn from the FCTC to illustrate the potential of using regulatory tools to denormalize industry practices. For instance, Art. 11 mandates the adoption of strict regulations on the packaging and labeling of tobacco products, including the implementation of health warnings, and Art. 13 prohibits the advertising, promotion, and sponsorship of tobacco products.¹⁸¹¹ These measures played a crucial role in “denormalizing” industry practices that were once considered standard.

Similar strategies could be applied to regulate the food and beverage industries. A decade ago, front-of-package labeling was virtually nonexistent in packaged foods, allowing ultra-processed foods high in sugar, fat, sodium, and harmful additives, such as trans fats (now banned in many countries), to dominate consumer choices. However, regulatory interventions have gradually shifted this landscape. Implementing mandatory FOP labeling on packaged foods establishes clear boundaries for the food industry, limiting deceptive marketing practices and enhancing consumer awareness. In addition, it enhances reformulation.

Concerning advertising and marketing strategies, the same pattern can be observed with tobacco control: before the FCTC and national legislation restricted the tobacco industry, companies were free to market their harmful products without constraints. Likewise, banning advertisements targeted at children is another essential step in curbing the influence of an industry that profits from promoting unhealthy dietary habits. For instance, kids growing up in Chile today do not have the image of the mascot “Tony the Tiger”.¹⁸¹² These measures, inspired by successful tobacco control policies, can help redefine societal norms and protect public health.

Thus, by recognizing the unethical practices of the food and beverage industries, similar to the recognition of such practices within the tobacco industry, it becomes possible to realign public

¹⁸¹⁰ See Part 2, Chapter 7, II, 1.

¹⁸¹¹ See Part 2, Chapter 5, II, 2.

¹⁸¹² Gilmore and others, ‘Defining and Conceptualising the Commercial Determinants of Health’ (n 328).

health promotion efforts and achieve significant progress in addressing non-communicable diseases.

A central criticism is that food differs fundamentally from tobacco because humans require food to survive, and food companies produce diverse products. However, it is possible to delineate boundaries. The focus should be on ultra-processed foods, which are typically high in sugar, salt, and fat while offering minimal nutritional value.¹⁸¹³ Likewise, attention should center on the industry that manufactures these products. Although many corporations have diverse portfolios (selling products that can be considered harmful to health while others are not), the focus should be on those companies whose core business model, dominant sales, or product portfolios are centered on ultra-processed foods or, more broadly, unhealthy food products¹⁸¹⁴. A working example would be companies in which the majority of their food portfolio consists of products considered “unhealthy food”, contributing to diet-related NCD risks.¹⁸¹⁵

The ultra-processed food industry, along with the tobacco, alcohol, and fossil fuels industries, are responsible for at least one-third of global deaths.¹⁸¹⁶ By prioritizing the regulation of these harmful products and recognizing their role in undermining public health, policymakers can take decisive steps to NCD prevention. In addition, states have the obligation to fulfill the right to health. Finally, international norms and standards are crucial to support countries in reclaiming their health sovereignty and counteracting “regulatory chill”.¹⁸¹⁷ The FCTC has been identified as an evidence-based foundation for national laws, thus making legal and normative pressure for domestic policy change.¹⁸¹⁸

2.2 Denormalizing Big Food and Big Soda at the domestic level: the Swiss Context

At the domestic level, rejecting PPPs as an alternative regulatory approach means that traditional command-and-control would be the mechanism to regulate the food industry and unhealthy foods.

¹⁸¹³ For a better understanding of unhealthy food and UPFS see Part 1, Chapter 1, 4.3 Unhealthy diet.

¹⁸¹⁴ The literature has identified which actors can be considered “Big Food” and “Big Soda”, as discussed throughout this thesis.

¹⁸¹⁵ Evans, ‘Nestlé Document Says Majority of Its Food Portfolio Is Unhealthy’ (n 42).

¹⁸¹⁶ Gilmore and others, ‘Defining and Conceptualising the Commercial Determinants of Health’ (n 328).

¹⁸¹⁷ Magnusson, ‘Global Health Governance and the Challenge of Chronic, Non-Communicable Disease’ (n 1803).

¹⁸¹⁸ *ibid.*

To denormalize the legal treatment of the food industry as public health partners, a practical application of industry denormalization strategies in Swiss federal law would be the introduction of mandatory FOP labeling. This measure could also help further denormalize unhealthy products themselves, and it could take the form of an amendment incorporated into the Federal Act on Foodstuffs. Specifically, this could involve amending Art. 12 on Mandatory Labeling and Information to explicitly require FOP nutrition labeling. Art. 13(h) grants the Federal Council the authority to regulate labeling requirements related to nutritional value. This could raise concerns that modifications in the legislation at the federal level are perceived as too difficult. An alternative pathway could be through amendments to the Federal Ordinance of the FDHA on Information on Foodstuffs.¹⁸¹⁹

Building on this precedent, a new provision, Art. 22a, could be introduced under the same Federal Ordinance of the FDHA on Information on Foodstuffs to establish mandatory FOP labeling. This provision could require that if a product exceeds set thresholds for critical nutrients such as sugar or salt (e.g., “high in sugar,” “high in salt”), it must carry a prominent warning label on the front of the package, similar to systems implemented in several Latin American countries. Such a measure would incentivize manufacturers to reformulate their products to contain less sugar or salt.

Additionally, fiscal measures such as the taxation of sweetened beverages, a strategy increasingly adopted worldwide, could also be recommended in this context. Taxing unhealthy products can incentivize reformulation, denormalize these products, and challenge the notion that reformulation should rely solely on voluntary agreements.

In a detailed analysis of adopting fiscal measures on sweetened beverage products in Switzerland, PETER-SPIESS explored the implementation through a change in the VAT rate.¹⁸²⁰ VAT is the general consumption tax at the federal level in Switzerland.¹⁸²¹ She suggests that the law could be amended by adding a second exemption to the reduced rate in Art. 25, para. 2, letter a, no. 2 VAT Act, in comparison with the case of alcohol.¹⁸²² Increasing the VAT rate of SSBs would align with the WHO position that SSBs should not be VAT-exempt or benefit from a lower VAT rate.¹⁸²³

¹⁸¹⁹ A recent example that illustrates the feasibility of such law reform was explained in Part 2, Chapter 7, III.

¹⁸²⁰ Peter-Spiess, *Food Regulation and Public Health: The Case off Sugar* (n 16) 124-125.

¹⁸²¹ *ibid.*

¹⁸²² *ibid.*

¹⁸²³ *ibid.*

Due to the possible challenges to the implementation of a modification to the VAT rate, PETER-SPIESS also explored the implementation through a special consumption tax with legal basis on the Art. 131, para. 1 Fed. Cst.¹⁸²⁴ Since there are no special consumption taxes on foods, the author concludes that an amendment to Art. 131, para. 1 Fed. Cst. or another constitutional basis would be required.¹⁸²⁵ Another pathway would be incentive taxes, which do not require a constitutional basis and can be introduced through a corresponding general material competence in the Swiss Federal Constitution, in this case Art 118 (health protection).¹⁸²⁶ Drawing on the examples of taxation systems already implemented for other unhealthy products, such as tobacco and alcohol, a special consumption tax could likewise be introduced.¹⁸²⁷

III Conclusion

Public-private partnerships for NCD prevention have been used as an avoidance mechanism to stricter regulation, normalizing the influence of the food and sweetened beverage industries in shaping public health policy. This section highlights the imperative to denormalize such collaborations, reconsider the role of these industries as public health partners, and regulate their practices as a critical step toward genuine public health promotion and NCD prevention.

The similarities between the tobacco, food, and sweetened beverage industries are well-documented and exposed. A central argument historically employed by the tobacco industry is the assertion that tobacco is a legitimate and legal product.¹⁸²⁸ As this research has demonstrated, the notion of “legal but harmful” products applies equally to unhealthy food products.

Attention has been paid to the issue of denormalizing obesity and the stigma this can create. This is not the aim of this hypothesis. This hypothesis centers on the denormalization of considering the food industry as a partner in public health policies, applying the same legal treatment from Art 5.3 of FCTC to avoid practices that undermine public health goals. The urgency for such a shift is underscored by the upcoming 2025 NCD High-Level Meeting, which

¹⁸²⁴ *ibid*, 128.

¹⁸²⁵ *ibid*.

¹⁸²⁶ *ibid*, 129.

¹⁸²⁷ *ibid*, 129-130.

¹⁸²⁸ S Chapman and B Freeman, ‘Markers of the Denormalisation of Smoking and the Tobacco Industry’ (2008) 17 *Tobacco Control* 25.

presents a unique opportunity to curtail industry influence by not incentivizing private sector involvement in public health policies.

The prevalence of non-communicable diseases remains a global crisis, yet many nations continue to repeat past mistakes by allowing industries with inherent conflicts of interest to influence public policies. Why should industries whose practices undermine public health objectives be given a role in shaping the policies meant to regulate them? Lessons from the “denormalization” of the tobacco industry, particularly the adoption of Art. 5.3 of the Framework Convention on Tobacco Control suggests a similar approach that could be applied to the food and sweetened beverage industries and denormalize PPPs for NCD prevention as a regulatory tool. As a result, the regulatory approach would be command-and-control measures towards the food industry and unhealthy foods. This can foster a social change in the consumption of unhealthy products, such as in the case of tobacco.

CONCLUSION

I Recapitulation of the findings

This thesis has explored public-private partnerships with the food and sweetened beverage industry as an alternative regulatory tool to stricter regulation for NCD prevention. The central research questions guiding this work were:

How did public-private partnerships with the food and sweetened beverage industries emerge as an alternative regulatory approach for NCD prevention? What is the definition of PPPs for NCD prevention, and how does it differ from traditional PPPs and global health PPPs? To what extent can PPPs function as an appropriate legal tool in this context, and what legal frameworks or safeguards are necessary to adapt them to better serve public health objectives?

To conclude, the thesis's main findings are presented below in a bullet point summary, corresponding to each core component of the analysis.

PART 1

- NCDs (cardiovascular disease, diabetes, cancer, and chronic respiratory conditions) are a major global public health concern. The key risk factors for NCDs are tobacco use, harmful alcohol consumption, and unhealthy diets. These factors are classified as “modifiable behavioral risk factors” since they are related to human behavior and lifestyle.
- Globalization, trade liberalization, and market integration have accelerated the nutrition transition, especially in LMICs, fueling the global spread of NCDs alongside persistent infectious diseases.
- NCD risk distribution is not equal. Individual dietary choices are deeply shaped, and often constrained, by social, economic, environmental, political, and cultural factors, which are unevenly distributed across society. This unequal distribution of NCD risks and the influence of social determinants of health mean that not everyone has the same opportunity to make healthy choices.
- A group of transnational corporations, known as Big Food and Big Soda, dominate the global market for ultra-processed foods and sweetened beverages, promoting products

high in sugar, salt, and unhealthy fats. Food corporations are central actors in the spread of diet-related NCDs, directly impacting population health by promoting and distributing their unhealthy products.

- The rise of NCDs is closely tied to commercial determinants of health (corporate practices, and profit-driven strategies that prioritize sales over well-being). These determinants reflect an inherent tension between public health goals and corporate interests, as seen in industries like tobacco, alcohol, and ultra-processed foods.
- In the field of NCD prevention, the role of law is perceived as an instrument or tool for promoting and safeguarding health. In the early 2000s, growing concerns about obesity and unhealthy diets spurred a “new public health movement” and a “new frontier of public health law,” shifting focus to NCDs, risk regulation, and healthier lifestyles, while also raising criticisms of paternalism as regulations intersected with private choice and individual rights.

PART 2

- NCDs are a human rights issue. Thus, a rights-based framework underpins legal responses to NCDs, with the right to health and the right to adequate food serving as core justifications for State action. States have the obligation to respect, protect, and fulfill the right to health.
- To understand the rise of PPPs as an alternative regulatory approach for NCD prevention is essential to examine the current legal framework for NCD prevention. Global health law has three main sources: international health law, the human right to health, and the interconnecting legal regimes that impact health. International trade law can create tensions with public health goals, sometimes limiting national regulatory space for NCD prevention measures, as in the context of FOP labelling.
- The international legal framework for NCD prevention is non-binding (exemption FCTC concerning tobacco), offering recommendations rather than enforceable obligations. Across global instruments tackling unhealthy diets, such as the WHO Global Strategy, the Global Action Plan, Political Declaration of the High-level Meeting on NCD, there’s a consistent call for the private sector (food industry) involvement

through multi-stakeholder engagement, partnerships, and multisectoral collaboration in NCD prevention.

- The EU legal framework for NCD prevention in the context of unhealthy diets has focused on voluntary measures and echoes the international approach of establishing public-private partnerships, with a strong emphasis on individual behavior and responsibility.
- At the domestic level, command-and control regulations are slowly growing in the area of unhealthy diets, with countries adopting SSBs taxes, marketing restrictions aimed at protecting children, and mandatory FOPL. However, it is limited. For instance, Switzerland's case study illustrates a strong preference for voluntary action over a stricter regulatory approach in addressing diet-related NCDs.
- The perceived limitations of traditional command-and-control regulations have led to the emergence of the “new governance” framework, which moves beyond a state-centered model, aspiring to be more open-textured, participatory, bottom-up, consensus-oriented, contextual, flexible, integrative, and pragmatic.
- Critiques of public health regulation, including concerns over paternalism and “nanny state” interventions, have fueled resistance to stronger legal measures. The argument of personal responsibility has been heavily supported by food industry, contributing to a greater reliance on private-sector participation, particularly through self-regulation and corporate social responsibility initiatives. However, such involvement raises concerns about “health washing”, where companies promote a public health image while continuing harmful practices.
- The combination of soft law global health instruments encouraging private sector involvement, the limited application of command-and-control regulations at the domestic level, the rise of “new governance” regulatory tools, persistent antipaternalistic critiques emphasizing “individual autonomy,” the perceived difficulty of regulating food industries since its tied to life's necessities (unlike tobacco), and the belief in the value of private sector expertise on their (unhealthy) products have all contributed to the conditions for the adoption of PPPs as an innovative alternative regulatory approach to stricter regulation for NCD prevention.

PART 3

- PPPs in general emerged as a form of public policy innovation within the neoliberal order, weakening the role of the public sector and favoring market-based solutions to public challenges. PPPs are frequently promoted on the premise that private actors possess greater technical expertise, innovation capacity, and operational flexibility.
- PPPs in general are broadly defined as long-term contracts between a private party and a government entity, for providing a public asset or service in which the private party bears significant risk and management responsibility, and remuneration is linked to performance. PPPs are considered “complex contracts” that assume diverse forms and differ in their regulation by domestic law.
- Although one of the main characteristics of PPP is the voluntary nature, it is widely recognized that regulatory measures are imperative to ensure the balance of public and private interests within these collaborative arrangements.
- Global health PPPs emerged in the late 1990s and early 2000s, shaped by neoliberal ideas about market efficiency and the private sector’s role in delivering health solutions and the idea that complex health challenges require collaborative approaches.
- Global health PPPs have a hybrid composition involving multiple partners, such as government, private industries, and intergovernmental organizations, and have the specific focus on developing drugs and vaccines. A new format of global health PPPs has been identified with a focus on improving the malnutrition (meaning undernutrition) of vulnerable populations in developing countries (this format starts to raise questions about the conflict of interest of the food industry).
- Global health PPPs are institutionalized to share resources and manage risks, typically governed by a board operating under formal statutes. However, due to their hybrid composition, they also involve complex legal frameworks, raising concerns about their status under international law and, consequently, their accountability mechanisms.
- Both types of PPPs raise concerns about the public-private dichotomy. The so-called “privatization of world politics” underscores that PPPs should be understood as a reconfiguration of the boundaries between the public and private spheres, reflecting a political effort to embed private interests more deeply within an “ever-shrinking” public sphere.

- By developing a taxonomy of the PPPs, this research adopts the following definition of public-private partnerships for NCD prevention: voluntary collaborations between the public sector (government entities) and the for-profit private sector (corporate sector/business) to address the challenges imposed by NCDs with the common aim of public health promotion via some degree of shared decision-making. They might include other partners, such as nonprofit partners or civil society. The interaction can occur in different formats: public education and information, product reformulation, research, access to healthy foods, and control of advertising, marketing, and promotion.
- The focus of this thesis has been PPPs for NCD prevention that center on food reformulation. Food reformulation has been characterized as a “promising public health strategy” that targets industry-level change rather than individual behavior, and it remains an alternative regulatory tool that countries still adopt.
- An analysis of selected case studies of PPPs with ultra-processed food and the sweetened beverage industries focused on food reformulation has shown that there is considerable diversity in the structure and operation of PPPs for NCD prevention.
- PPPs for NCD prevention tend to be effective only when industry interests align with public health objectives, as exemplified by the Danish Whole Grain Partnership, an institutionalized scheme with shared governance.
- In the case of the Responsibility Deal, industry misalignment with the goal of public health promotion, characterized by its loose structure (lack of defined measurable targets, monitoring mechanisms, enforceable consequences, and authority oversight), highlights the limitation of this approach as an alternative regulatory tool to command-and-control regulations.
- The voluntary sodium reduction targets in the US also demonstrate the pitfalls of relying on industry goodwill, given the lack of systematic monitoring, enforceable accountability, and penalties for non-compliance.
- The Declaration of Milan is an attempt of PPPs formalized through a memorandum of understanding that includes defined targets and the right to cancel the partnership, which at first glance might seem promising. However, without strong oversight by authorities and enforceable consequences, such provisions remain largely symbolic and fail to ensure meaningful outcomes.

- In a comparative analysis between PPPs in general, global health PPPs, and PPPs for NCD prevention, there are key differences. First, the idea of a common goal in PPPs for NCD prevention is problematic, given the fundamental misalignment between the interests of the food industry and the objectives of public health. These partnerships introduce an added layer of complexity due to the inherent conflicts of interest, as corporations producing ultra-processed foods and sugar-sweetened beverages are interested in increasing their profits through their unhealthy products (products that contribute to the NCD burden). In addition, the idea of “sharing risks and benefits” is notably absent in these PPPs. In practice, private actors secure the benefits without bearing meaningful risks, while the public sector assumes significant risks to public health with little to no corresponding benefit.
- Traditional PPPs are, in most cases, public contracts governed by administrative law, with clear compliance mechanisms and legal accountability. In these PPPs, private actors bear legal and financial consequences if they fail to meet targets. In NCD prevention, failure to meet established targets rarely results in sanctions, undermining accountability.
- Traditional PPPs have shown success in delivering outcomes (e.g., Operation Warp Speed), while global health PPPs have mobilized funding and innovation for neglected diseases. By contrast, PPPs for NCD prevention mostly fail to achieve health promotion due to structural weaknesses and conflicts of interest.
- PPPs for NCD prevention raise numerous legal concerns that range from normative questions to practical issues. A detailed analysis through the lens of public-private dichotomy shows that these types of PPPs, like PPPs in general and global health PPPs, blur the boundaries between private and public spheres. In PPPs for NCD prevention, there are two critical points (1) allowing private actors to decide about public health objectives resulted in a regulatory gray zone, a no man’s land towards the food industry; and (2) PPPs typically are justified due to their efficiency in delivering public services (which is the case for infrastructure projects), however in the context of NCD prevention, as shown within the case studies, they mostly fall short of effectively promoting public health and preventing NCDs. In reality, PPPs for NCD prevention are used as a regulation avoidance mechanism, prioritizing corporate interests over public health objectives; therefore, this dynamic defies its own normative purpose: promoting public health and preventing NCDs.

- Concerning COI, it is imperative to recognize that the corporate interests (considered a second interest) must not unduly influence the primary interest of States, namely, the public health interest. States bear the fundamental obligation to safeguard the right to health and adequate food. Consequently, any collaborations established with industries involved in the production of ultra-processed foods and sweetened beverages must be subject to meticulous scrutiny and authority oversight.
- While lobbying is not a novel phenomenon, concerning PPPs for NCD prevention, lobbying often operates not merely as a means to influence the specifics of regulation, but to reshape the regulatory approach itself. Industry actors have actively lobbied in favor of PPPs as an alternative to command-and-control approaches in the context of NCD prevention, ultimately using them as an avoidance mechanism to regulation.

PART 4

- Considering that PPPs are still measures adopted through different jurisdictions to tackle NCDs, such as the Declaration of Milan and the US Voluntary Sodium Reduction Goals, the first hypothesis proposes a contractual framework inspired by the formal contractual models of traditional PPPs. This proposed framework draws on principles from public health literature and human rights, such as transparency and accountability, to establish a formal agreement that clearly defines roles and includes enforceable sanctions, thereby structuring voluntary collaborations. It is important to remember that States still have the obligation to the right to health. Therefore, the involvement of private actors here, such as in PPPs in general, does not absolve the state of its primary obligations.
- Traditional PPPs use formal contracts with clear, measurable deliverables, risk management, and enforcement mechanisms. This model should be adapted to voluntary food industry agreements by including government-set targets (e.g., ingredient reductions by product category), transparent monitoring, authority oversight, and strong accountability measures such as enforceable sanctions for non-compliance (termination of the partnership and the adoption of stricter regulation), and elements of “shaming”.
- The second hypothesis acknowledges that the inherent conflicts of interest between public health goals and food industry profit motives fundamentally undermine the

adoption of PPPs for NCD prevention as a viable “innovative alternative regulatory tool” capable of genuinely advancing public health and preventing NCDs.

- Drawing from tobacco control, this approach applies the denormalization theory in two ways: first, at the international level, a similar approach to Art. 5.3 of the FCTC could be applied to the food industry to foster the denormalization of PPPs with risk-creating industries (Big Food and Big Soda). Second, at the domestic level, denormalizing the use of PPPs as an alternative regulatory tool would involve the adoption of command-and-control regulation, such as mandatory front-of-package labeling and fiscal policies, which can also denormalize unhealthy products
- Instead of stigmatizing people with obesity, efforts at denormalization should focus on treating the food industry not as a partner in public health policy, but as an actor whose influence should be limited.

II Closing remarks

The prevention of non-communicable diseases remains a major public health challenge, and the legal framework addressing this issue is still evolving. Historically, the legal responses for NCD prevention have been shaped by the notion of individual responsibility, new governance regulatory tools, paternalistic critics of command-and-control regulations and the narrative that the private sector must be engaged in dealing with complex health challenges.¹⁸²⁹ Nonetheless, there has been a growing recognition of the food industry as a “major driver of the non-communicable disease epidemic”.¹⁸³⁰

The legal architecture for NCD prevention continues to face significant gaps, particularly regarding the legal approach to food corporations and their unhealthy products. There is consensus in the literature regarding the inherent limitations associated with PPPs for NCD prevention and the need for stricter regulation to mitigate the harms of unhealthy diets.¹⁸³¹ Nonetheless, governments continue to rely on voluntary agreements to encourage food industries to reformulate their products as one strategy in this scenario. Notable examples

¹⁸²⁹ See Part 2, Chapter 8.

¹⁸³⁰ See Part 1, Chapter 2, II.

¹⁸³¹ See for example Fooks and Godziewski, ‘The World Health Organization, Corporate Power, and the Prevention and Management of Conflicts of Interest in Nutrition Policy Comment’ (n 1570); Garde, ‘The Lack of Coherence in the European Union’s Approach to Noncommunicable Disease Prevention’ (n 653); Marks, *The Perils of Partnership* (n 1188).

include Switzerland's Declaration of Milan and the United States' Voluntary Sodium Reduction Goals.

There is a need to rethink the unique legal treatment of the food industry compared to the tobacco industry. The argument that food is essential for life, unlike tobacco, has long been used to justify the adoption of these PPPs with the food industry and not limiting their activity, for instance, the absence of a global binding instrument akin to the Framework Convention on Tobacco Control for the food sector.

As I started writing this thesis, my primary question was whether public-private partnerships could be established for non-communicable disease prevention and public health promotion. However, as I delved deeper into the topic, I realized that such collaborations were being adopted in various forms across different legal jurisdictions. Therefore, I shifted my focus toward understanding the legal architecture that made it possible for the development of these PPPs as alternative regulatory tools to command-and-control regulations.

I also recognized the need to establish a more precise definition of these partnerships, as they are often mixed with private initiatives like corporate social responsibility and self-regulation. Drawing from the broader taxonomy of PPP frameworks, this research developed a definition of PPPs for NCD prevention by situating them within the context of PPPs in general and global health PPPs models and legal frameworks.¹⁸³² By clarifying this definition and making these comparisons, the analysis offers a more structured and rigorous understanding of the role of these partnerships within public health law. PPPs for NCD prevention differ from PPPs in general and global health PPPs models because of the inherent conflict of interest of the private sector involved in these partnerships, which leads to a fundamental misalignment between the food industry's objectives (maximize profit of unhealthy products) and the common goal of public health promotion and NCD prevention.

Despite extensive scientific evidence demonstrating that these collaborations are largely ineffective in tackling the burden of NCDs, the WHO and national governments still encourage them.¹⁸³³ The predominance of "soft" law approaches, coupled with the emphasis on cross-sector collaboration at the international and regional levels, the "new governance" theory, neoliberalism beliefs and resistance to perceived paternalistic interventions at the domestic

¹⁸³² See Annex 1, Table: Comparative Taxonomy of PPP.

¹⁸³³ See for example, Moodie and others, 'Profits and Pandemics' (n 34); Knai and others, 'Has a Public-Private Partnership Resulted in Action' (n 1292).

level, has created a regulatory gap that has allowed voluntary agreements with the food industry to emerge as a public health alternative regulatory tool.¹⁸³⁴

Food industry stakeholders have secured a place in health and nutrition policymaking, shaping the discourse around NCD prevention. This research aimed to critically examine selected examples of these partnerships to understand their potential and limitations within NCD prevention. The most pressing concern remains the inherent conflict of interest: the food industry has the commercial interest to promote and maximize the sales of its unhealthy products, products that are, in fact, driving the burden of NCDs in society. In addition, from a theoretical perspective, these partnerships often serve as a regulation avoidance mechanism, ultimately defying their normative purpose: NCD prevention and public health promotion.¹⁸³⁵

Academic discourse has largely moved beyond the notion of personal responsibility, recognizing the role of social and commercial determinants of health in the burden of NCDs.¹⁸³⁶ Nevertheless, a laissez-faire approach to NCD prevention persists. Therefore, concerning PPPs for NCD prevention, I see two possible avenues.

The first is a legal pragmatic one, to address the current reality. If voluntary agreements are to continue, they must operate within a robust contractual framework that clearly defines roles, sets measurable targets, includes monitoring mechanisms, authority oversight, and sanctions for non-compliance, features typical of traditional PPPs.

Alternatively, if the goal is to rethink and challenge the current legal framework for NCD prevention, it becomes necessary to denormalize the view of these industries as partners in public health, recognizing them as being only “part of the problem” and not “part of the solution”. Echoing TOEBES’ powerful words, adopting treaties on food and alcohol within the next decade could profoundly enhance global public health.¹⁸³⁷ At the international level, a similar approach to Art. 5.3 of the FCTC could be adopted by rejecting public-private partnerships with the food industry to limit their involvement in public health policymaking. As the adoption of the FCTC fostered global change in tobacco control, international action on unhealthy food products and the food industry could exert legal and normative pressure, leading to transformative shifts at the domestic level.¹⁸³⁸ As GARDE pointed out, “law is a key

¹⁸³⁴ See Part 2.

¹⁸³⁵ See Part 3, Chapter 11, II and IV.

¹⁸³⁶ See Part 1, Chapter 1, II and Part 1, Chapter 2, II.

¹⁸³⁷ Toebes, ‘Global Health Law as a Foundation for NCD Prevention’ (n 374).

¹⁸³⁸ Magnusson, ‘Global Health Governance and the Challenge of Chronic, Non-Communicable Disease’ (n 1803).

instrument for the development and implementation of effective NCD prevention strategies”.¹⁸³⁹ Thus, at the domestic level, in place of voluntary agreements to salt and sugar reduction, governments should adopt stricter regulatory measures targeting unhealthy products, such as mandatory front-of-package labelling and taxation, to drive meaningful shifts at the industry-level that will shape societal consumption patterns concerning unhealthy food products and genuinely promote public health and the prevention of NCDs.

¹⁸³⁹ Garde, ‘Global Health Law and Non-Communicable Disease Prevention’ (n 37) 396.

ANNEX 1

Table: Comparative Taxonomy of PPP

Aspect	Traditional PPPs	Global Health PPPs	New Format Global Health PPPs	PPPs for NCD Prevention
Definition	Voluntary collaborations between state and non-state actors in which all participants agree to work together to achieve a common purpose or undertake a specific task and to share risks and responsibilities, resources and benefits	Voluntary long-term collaborations among diverse stakeholders to jointly pursue public health goals	Voluntary collaborative agreements from civil society, the UN, donors, businesses, researchers, and governments to improve the nutrition of vulnerable populations	Voluntary collaborations between governments and the for-profit sector to tackle NCDs with the common aim to promote public health via some degree of shared decision-making
Common Goal	Yes	Yes	Borderline: Industry misalignment	Industry misalignment
Shared risks and benefits	Yes	Yes	Borderline	Public sector: risks but no benefits Private sector: benefits and no risks
Legal framework	Contractual frameworks; domestic contracts compliance penalties legal with and	Formalized under international or domestic laws (e.g., GAVI under Swiss law)	Formalized structure	Lack of legal framework; operates in regulatory grey zones

Human rights	States remain bound by the tripartite levels of obligations to respect, protect, and fulfil human rights Private sector: UNGPs and General Comment No. 24	States remain bound by the tripartite levels of obligations to respect, protect, and fulfil human rights Lack of international personality (accountability issue)		States remain bound by the tripartite levels of obligations to respect, protect, and fulfil human rights Private sector: UNGPs (lack of recognition of the food industry)
Focus	Public services and infrastructure	Drug/vaccine development and access in low-income countries	Combatting undernutrition/ending malnutrition	Health promotion (education, reformulation, marketing restrictions, etc.)
Partners	Government and private sector	Governments, intergovernmental organizations, private sector (NGOs, companies, research)	Governments, intergovernmental organizations, civil society, NGOs, donors, and businesses	Governments, food industry (might include civil society)
Examples	Operation Warp Speed (US)	GAVI Alliance, Global Fund.	GAIN, Scaling Up Nutrition (SUN)	UK Public Health Responsibility Deal
Outcomes	Effective in delivering infrastructure/public services	Effective in mobilizing resources, raising awareness, and delivering vaccines/drugs for neglected diseases	Effective in tackling undernutrition	Ineffective in achieving health outcomes; limited impact on food reformulation

Risks and concerns	Blurred lines between public and private roles; delegation of public functions	Blurred lines between public and private roles and private influence on public health governance	Similar concerns over private influence on public health governance and conflict of interest	Blurred lines between public and private roles; commercial determinants of health and conflict of interest
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